Supreme Court, U.S.
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92-629

No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1992

GRAYCE AUL, individually, AUL PIPE & TUBING, INC., as a Fiduciary of the Aul Pipe & Tubing, Inc. Employee Welfare Benefit Plan, and HENRY AUL as an Administrator of the Aul Pipe & Tubing, Inc. Employee Welfare Benefit Plan,
Petitioners,

vs.

ALLSTATE LIFE INSURANCE COMPANY, and OLD KENT BANK, as Trustee of the First Insurance Trust,
Respondents.

PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

I. UNDER ERISA CAN AN INSURANCE COMPANY WHICH SELLS A HEALTH POLICY PROVIDING FOR "LIFETIME" COVERAGE, CANCEL THE POLICY AFTER THE INSURED CONTRACTS A COVERED ILLNESS AND THEREBY AVOID PAYING FOR MEDICAL EXPENSES INCURRED AFTER THE DATE OF TERMINATION?

II. UNDER ERISA DOES THE RULE OF *CONTRA PROFERENTEM* APPLY IF THE TERMS OF A HEALTH INSURANCE POLICY ARE SUBJECT TO MORE THAN ONE INTERPRETATION?

III. IS THE OPINION OF THE COURT IN *FIELDS V. BLUE SHIELD OF CALIFORNIA*, 163 CAL.APP.3D 570 (1985) DECISIONAL LAW REGULATING INSURANCE IN CALIFORNIA PURSUANT TO 29 U.S.C. § 1144(b)(2)(A)?

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IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1992

GRAYCE AUL, INDIVIDUALLY, AUL PIPE & TUBING, INC. AS A FIDUCIARY OF THE AUL PIPE & TUBING, INC. EMPLOYEE WELFARE BENEFIT PLAN, AND HENRY AUL AS AN ADMINISTRATOR OF THE AUL PIPE & TUBING, INC. EMPLOYEE WELFARE BENEFIT PLAN,

Petitioners,

vs.

ALLSTATE LIFE INSURANCE COMPANY, AND OLD KENT BANK, AS TRUSTEE OF THE FIRST INSURANCE TRUST,

Respondents.

PETITION FOR WRIT OF CERTIORARI

The petitioners respectfully pray that a writ of certiorari issue to review the judgment and order of the United States Court of Appeals for the Ninth Circuit.[1]

OPINIONS BELOW

The Order denying the petition for rehearing of the Court of Appeals for the Ninth Circuit dated July 15, 1992, is attached as Appendix A. The Memorandum of the Court of Appeals for the Ninth Circuit dated January 22, 1992, is attached as Appendix B. The Order re Defendant's Motion to Dismiss or for Summary Judgment of the United States District Court for the Central District of California dated August 30, 1990, is attached as Appendix C.

JURISDICTION

Federal jurisdiction in conferred under 29 U.S.C. §1132(e)(1). The Memorandum of the Court of Appeals was entered on January 22, 1992 (Appendix B). A timely petition for rehearing with suggestion for hearing en banc was denied by an order entered July 15, 1992

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[1] The parties to the proceedings before the United States Court of Appeals were those indicated by the case caption.

(Appendix A). Accordingly, the instant petition is timely pursuant to Rule 13.4 of the Rules of the Supreme Court of the United States. The jurisdiction of this Court to review the judgment by writ of certiorari is conferred under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS

This petition involves 29 U.S.C. § 1001 et seq. (ERISA) and in particular 29 U.S.C. §§ 1144(b)(2)(A) and 1144 (c)(1) which provides in part:

> "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
>
> "The term 'State law' includes all laws, decisions, rules, regulations, or other state action having the effect of law, of any state."

STATEMENT OF THE CASE

In April, 1981, Aul Pipe & Tubing, Inc. applied for coverage under Allstate Life Insurance Company's master insurance policy for life, accidental death and

dismemberment and comprehensive medical insurance (the "Policy") for employees and their dependents. Aul Pipe & Tubing, Inc. obtained coverage effective May 1, 1981. Grayce Aul was a beneficiary under the Policy as a dependent of her husband Henry Aul. In 1982 Grayce Aul was diagnosed as suffering from degenerative liver disease and began receiving treatment for that disease. Treatment has continued through the present date. [2]

ALLSTATE issued approximately 14,000 policies covering over 42,000 people (Appendix G, p. G-2). On February 17, 1989, ALLSTATE notified AUL (and all other policy holders) that the group policy would terminate on May 1, 1989, at 12:01 a.m. In December, 1989, Grayce Aul received a liver transplant and incurred approximately $250,000.00 in medical and hospital bills. ALLSTATE denied coverage for these bills incurred after the termination date of the Policy, May 1, 1989, even though they were incurred as a result of an illness covered by the Policy and incurred while the Policy was in force.

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[2] Petitioners are hereinafter collectively referred to as "AUL" and Respondents are collectively referred to as "ALLSTATE."

AUL filed a class action against ALLSTATE for (1) breach of contract under ERISA and federal common law, (2) breach of fiduciary duties under ERISA, (3) breach of statutory duties under ERISA, (4) equitable and promissory estoppel, (5) declaratory relief, and (6) injunctive relief.

ALLSTATE filed a motion to dismiss or in the alternative for summary judgment. In its motion ALLSTATE contended, *inter alia*, that (1) the Policy was not ambiguous and contained an express provision allowing termination; (2) the Policy provided that only expenses incurred while the policy was in force were to be paid; (3) ALLSTATE had an absolute right to terminate and, therefore, there was no breach of any fiduciary obligations under ERISA; and (4) the insureds were not entitled to vested benefits. AUL, in opposing the motion argued, *inter alia*, that (1) the Policy and advertisements for the Policy provided for "lifetime" medical benefits for an injury or illness that occurred before termination; (2) ambiguities in the Policy must be construed in favor of the insured; (3) Grayce Aul's rights to lifetime benefits vested at the time she became ill since the onset of her illness took place while the Policy was in force; and (4) AUL's rights vested under *Fields v. Blue Shield of California,* 163 Cal.App.3d 570, 209

Cal.Rptr. 781 (1985).

The issue before the District Court was whether the language of the Policy creates "lifetime" benefits for illnesses that arise before termination of the insurance.[3] The Policy provided for "lifetime" benefits for covered illnesses. ALLSTATE contended, however, that because the Policy also contained a termination provision, ALLSTATE had the power to unilaterally terminate the Policy and the "lifetime" benefits.

There is no ERISA limitation precluding an insurance carrier from contracting to pay for medical expenses incurred after termination of the policy for an illness contracted during the term of the policy. The contract language determines whether an insured is entitled to benefits for illnesses that arose before the policy. Thus, an insured's rights may become fixed or "vested" upon the onset of a covered illness if the policy so provides.

---

[3] The District Court found that ERISA does not prohibit an insurer and an insured from contracting for vested rights (Appendix C, p. C-15).

The relevant provisions of the Policy here are found in the Certificate of Coverage, the Certificate Booklet, and Certificate Amendments.[4]

The Certificate of Coverage is a single page document, which an insured is most likely to read, and provides in part:

> **"MEDICAL MAXIMUM:**
> **$1,000,000.00 DURING AN**
> **INSURED PERSON'S LIFETIME"**
> (Appendix D, p. D-1).

There is no language in the Certificate which discloses that if the Policy is terminated, "lifetime" benefits will cease as to illnesses incurred during the time the Policy is in force.

Provisions in the Certificate Booklet similarly mandate the conclusion that an insured's "lifetime" benefits vest for any illness contracted before termination of the Policy. The language of the Policy in the section entitled COMPREHENSIVE MEDICAL INSURANCE provides:

---

[4] ALLSTATE advertised the Policy as providing for "lifetime" protection, "No lifetime maximum limit!" (Appendix F).

> **"The Medical Benefit is paid for Eligible Expense incurred for an Injury or Sickness while insured.**
>
> **"'Eligible Expense' means the following types of Expense incurred for an Injury or Sickness while insured: . . .**
>
> **"'Expense' means a charge a person is legally obligated to pay. 'Expense' is deemed to be incurred on the date the service or supply is furnished"** (Appendix E, p. E-3).

AUL contended that this language can reasonably be interpreted to mean that an insured is entitled to "lifetime" benefits for any covered illness incurred during the term of the Policy. The phrase "while insured" refers to the onset of the injury or illness, thereby creating the right to "lifetime" benefits if the injury or illness occurs while the Policy is still in force.

The Certificate Booklet in two places within TERMINATION OF INSURANCE under the subsection relating to "Employee's Insurance" and the subsection relating to "Termination of Insurance -- Dependent's Insurance -- Medical Expense Insurance" provides as follows:

> **"The end of insurance will not affect any claim made for a *loss* that took place while the insurance was in force"** (Emphasis added) (Appendix E, p. E-2).

AUL contended that the term "loss" could reasonably be interpreted to refer to an injury or an illness that took placed while the Policy was in force. The term "loss" was not defined in the Policy. Indeed, had ALLSTATE used the defined term "Eligible Expense" in place of the word "loss" the sentence would read, "The end of insurance will not affect any claim made for an Eligible Expense that took place while the insurance was in force." The use of the defined term "Eligible Expense" would clarify that termination would not affect an insured's claim for the cost of medical treatment incurred before the Policy was terminated. Use of the broader term, "loss," however, indicates that the Policy will cover medical expenses incurred after the Policy has terminated for an injury or illness that occurred while the Policy was in force.

On August 30, 1990, the District Court granted the defendant's motion for summary judgment ruling that (1) in spite of the reference to "lifetime" benefits and the express statement that "[t]he end of insurance will not

affect any claim made for a loss that took place while the insurance was in force," the Policy was not ambiguous and gave ALLSTATE the right to terminate coverage; (2) advertising materials produced by ALLSTATE referring to "lifetime" benefits were not to be considered because the Policy was not ambiguous; (3) under the terms of the Policy health benefits did not vest at the time the illness was contracted because to so hold would "invite an interpretive horror" (Appendix C, p. C-22); and (4) *Fields v. Blue Shield of California* does not govern because to do so would be an "extension of the federal law" (Appendix C, p. C-11).

The United States Court of Appeals for the Ninth Circuit affirmed the District Court judgment and filed its Memorandum Opinion on January 22, 1992. The Memorandum Opinion held that (1) interpretation of ERISA insurance polices is governed by "uniform federal common law" and where appropriate federal courts should borrow from state law (Appendix B, pp. B-2, B-3); (2) the term [in the Policy] "Eligible Expense" refers to expenses incurred while insured, not expenses arising from a sickness while insured; (3) the use of the term "lifetime" does not manifest any intention to vest the insured's benefits if an illness is contracted during the policy period; (4) no ambiguity exists as to the

interpretation of the Policy language pertaining to vesting of benefits (Appendix B).

On February 5, 1992, AUL timely filed a Petition for Rehearing and Petition for Rehearing With Suggestion for Hearing En Banc. The United States Court of Appeals for the Ninth Circuit on July 15, 1992, denied AUL's Petition for Rehearing and rejected the Suggestion for Rehearing En Banc (Appendix A).

REASONS FOR GRANTING THE WRIT

I. THIS COURT SHOULD ESTABLISH THAT UNDER ERISA HEALTH INSURANCE POLICIES PROVIDING FOR "LIFETIME" BENEFITS CONFER A VESTED RIGHT TO BENEFITS FOR ANY ILLNESS CONTRACTED DURING THE POLICY PERIOD.

ALLSTATE sold health insurance policies to approximately 14,000 ERISA plans covering over 42,000 people throughout the United States (Appendix G, p. G-2). One of the selling features of the policies was that if an individual became ill, he would be covered up to the policy limit for his lifetime.

The purpose of ERISA is to protect the rights of individuals who are beneficiaries of employee welfare benefit plans. 29 U.S.C. §1001. In the present case, ERISA has been used by ALLSTATE to deprive beneficiaries of the protection of state laws and to circumvent its contractual obligation to provide "lifetime" benefits to beneficiaries who become ill while the Policy was in force. The issue to be determined by this Court is whether under ERISA an insured's right to coverage vests as of the time an illness occurs in health insurance policies that provide for "lifetime" benefits.

Many courts in different jurisdictions have held that an insured is entitled to "vested" benefits under a health policy after termination if the illness arose during the policy, even where the policy did not provide for "lifetime" benefits. The Louisiana Supreme Court examined this issue and found that an insured has vested rights under a policy when the illness occurs, which may not be circumvented by terminating the policy:

> "Cataldie bargained for and reasonably expected to obtain $250,000 in major medical insurance in the event a catastrophic disease should attack his family. Blue Cross bargained for and reasonably should have expected to be

> exposed to this risk. By waiting until the risk had been realized before bringing about cancellation of the policies, Blue Cross made it impossible for Cataldie to obtain insurance for his daughter Amie from any other carrier." *Cataldie v. Louisiana Health Service and Indemnity Co.*, 456 So.2d 1373, 1376 (La. 1984).

The Louisiana Supreme Court in reviewing how other jurisdictions treated the question of vesting found:

> "When confronted with this type of situation all modern authorities we have found conclude that the policy cannot be terminated as to illness, injury or condition arising before the insured's cancellation. They differ only as to the theory of decision: **Ambiguity** -- *Sparks v. Republic National Life Insurance Co.*, 132 Ariz. 529, 647 P.2d 1127 (1982), cert. den. 459 U.S. 1070, 103 S.Ct. 490, 47 L.Ed.2d 632 (1982) (cancellation of medical benefits policy); **Public Policy** -- *Brown v. Blue Cross and Blue Shield of Mississippi*, 427 So.2d 139 (Miss. 1983) (cancellation of medical benefits); *Gulf Guaranty Life Insurance Co. v. Kelley*, 389 So.2d 920 (Miss. 1980) (attempted

cancellation of credit life policy following insured's heart attack); **Detrimental Reliance** -- *Mutual Ben. Life Ins. Co. v. Robinson*, 54 F. 580 (C.A. Iowa) aff'd 58 F. 723 (8th Cir. 1893); **Implied Covenant of Good Faith** -- *Spindle v. Travelers Insurance Co.*, 136 Cal.Rptr. 404, 66 Cal.App.3d 951 (2d. Dist. 1977) (cancellation of medical malpractice policy). **Reasonable Expectations of Insured Honored** -- *See*, Keaton Insurance Law Rights at Variance with Policy Provisions, 83 Harv.L.Rev. 1961 (1970)." (emphasis added). *Cataldie, supra*, at 1376.

In *Lutsky v. Blue Cross Hospital Service, Inc.*, 695 S.W.2d 870 (Mo. 1985), the Missouri Supreme Court considered whether benefits "vest" for medical expenses following policy termination for an illness contracted during the policy. The policy provided benefits, "up to the lifetime maximum of $1,000,000.00 per person." *Lutsky, supra*, at 872. The Missouri Supreme Court ruled that benefits continue after termination for a condition that existed before the policy ended:

> "Numerous cases, over the years, have dealt with a problem of medical expense occasioned by accident or illness

commencing while insurance coverage is in force and continuing after the governing policy terminates through expiration, lapse, program modification, or otherwise. When the event insured against is accident or illness there is a tendency to hold that benefits payable to the insured for an existing condition continue in accordance with policy terms in force at the onset, even though the governing policy is terminated or modified while hospitalization or treatment is still necessary.

"If the defendants are correct, then the provision for $1,000,000.00 lifetime benefits per person is illusory to the point of being positively deceptive. This provision might lead members to believe that they would be protected against catastrophic and prolonged illness which strikes all too often without warning, whereas, by the defendants' contentions, the protection would continue only so long as the insurer and the sponsor did not change the coverage. By the defendants' argument, indeed, modifications could be made in order to forestall further payments on account of an existing disability. Such a state of affairs, at the very least, is occasion for a raising of the judicial eyebrow." *Lutsky, supra*, at 874-875.

The Arizona Supreme Court in *Sparks v. Republic National Life Ins. Co.*, 132 Ariz. 529, 647 P.2d 1127 (Ariz. 1982) reached the same conclusion. The policy

provided for "full benefits of up to $250,000 per person." The insurance company contended that medical expense benefits would cease on termination of the insurance coverage, in part because the section under "MAJOR MEDICAL BENEFITS" stated: "When as the result of Accidental bodily injury or sickness, an Insured Person incurs Covered Expenses shown herein *while this insurance is in force*. . . ." (emphasis added). The Arizona Supreme Court held that coverage vested at the time the injury was incurred and that the insurer was obligated to pay benefits after the policy was terminated. The Court noted that if an insurer desired to limit its liability under the policy, it must employ language which clearly and distinctly communicated to the insured the nature of the limitation. The insurer failed to set forth the limitation under the "Definitions and Exceptions" or "LIMITATIONS" section of the policy, as ALLSTATE also failed to do.

In all state cases, save one, where the policy provided for "lifetime" or fixed maximum benefits without express limitations, courts have held that benefits must be paid after termination. *See e.g., Danzig v. Dikman*, 434 N.Y.S.2d 217, 220-221 (1980); *Crum-Vanlandingham v. Blue Cross Health Services, Inc.*, 734 S.W.2d 266 (1987); *Fields v. Blue Shield of California*, 163 Cal.App.3d 570 (1985); *Wardlow v. Kalispell General Hospital*, 164 Mont. 59, 518 P.2d 1164 (1974); *Faruque v. Provident Life & Acc. Ins. Co.*, 31 Ohio St.3d 34, 508 N.W.2d 949 (1987); and *Myers v. Kitsap Physicians Service*, 78 Wash.2d 286, 474 P.2d 109 (1970).

The only case in which a court has held that an insured's rights do not vest in a policy providing "lifetime" benefits is the ruling by the Court of Appeals of Minnesota in *Sonneman v. Blue Cross and Blue Shield of Minnesota*, 403 N.W.2d 701 (Minn. 1987). The decision in *Sonneman*, however, was based on the fact Sonneman was a State employee, and the State, as an employer, had negotiated the reduction in benefits to achieve broader coverage desired by a majority of State employees. The State was acting on behalf of all of its employees, like a union representative. The State agreed to reduce benefits for a limited minority in order to increase benefits for a majority of its constituents. The bargained for consideration in reducing psychiatric care was the increase in benefits for other medical expenses. *Sonneman* is also distinguishable from the present case and from cases such as *Fields v. Blue Shield of California*, 163 Cal.App.3d 570 (1985) because the insurance company did not act unilaterally to terminate or modify the policy.

Unless the insurer limits the benefits to expenses occurring during the policy period and does not provide for "lifetime" benefits, the uniform modern rule of insurance contract interpretation is that when the insured event occurs -- the injury, accident, or illness -- the insured's rights vest, and benefits must be paid even after the insurer lawfully terminates the policy. This rule should be equally applicable to health policies governed under ERISA.

II. THIS COURT SHOULD ESTABLISH THAT UNDER ERISA AS A MATTER OF FEDERAL COMMON LAW, AMBIGUITIES IN AN INSURANCE CONTRACT ARE CONSTRUED UNDER THE RULE OF *CONTRA PROFERENTEM*

The Ninth Circuit in *Kunin v. Benefit Trust Life Ins. Co.*, 898 F.2d 1421 (9th Cir. 1990), amended, 910 F.2d 534 (9th Cir. 1990) specifically held that when an insurance contract contains an ambiguity, California insurance law is representative of the prevailing view in all states and will be incorporated in federal common law as a necessary component of ERISA. This rule of interpretation requires that ambiguities in insurance contracts be construed against the insurer. *Kunin* held that coverage clauses are interpreted broadly in favor of coverage while exclusions are interpreted narrowly:

> "According to the law of California and, indeed, every other state as well as the District of Columbia, ambiguities in insurance contracts must be construed against the insurer. This rule of *contra proferentem* has been called 'the most familiar expression in the reports of insurance cases.'. . .

"Of course, neither the law of California nor that of any other state is applicable here of its own force. The group health and medical policy that covers Kunin is an 'employee welfare benefit plan' as defined by ERISA, 29 U.S.C. sec. 1002(1); section 502 of ERISA, rather than state contract law, provides the legal basis for Kunin's claim. . . As we noted above, the *contra proferentem* rule is followed in all 50 states and the District of Columbia and with good reason. Insurance policies are almost always drafted by specialists employed by the insurer. In light of the drafter's expertise and experience, the insurer should be expected to set forth any limitations on its liability clearly enough for a common lay person to understand; if it fails to do this, it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence. Moreover, once the policy language has been drafted, it is not usually subject to an amendment by the insured, even if he sees an ambiguity; an insurer's practice of forcing the insured to guess and hope regarding the scope of coverage requires that any doubts be resolved in favor of the party who has been placed in such a predicament. Were we to

> promulgate a federal rule, we would find these common-sense rationales sound. Indeed, it would take a certain degree of arrogance to controvert an opinion held with such unanimity in the various states and to adopt a contrary view as a federal rule. We hold, therefore, that the rule of *contra proferentem* applies to the case at bar, regardless of whether it applies as a matter of uniform federal law or because federal law incorporates state law on this point." *Kunin*, *supra* at 540.

Following *Kunin*, the Ninth Circuit in *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437 (9th Cir. 1990) held that "interpretation of ERISA insurance policies is governed by a uniform federal common law." *Evans*, *supra*, at 1439. *Evans* did not, however, articulate the "uniform federal common law." If *Evans* stands for the proposition that the rule of *contra proferentem* will be applied as federal common law, it is not in conflict with *Kunin*. If, however, *Evans* holds that interpretation of ERISA insurance policies is not governed by the doctrine of *contra proferentem*, but by some unarticulated "uniform federal common law," it is in direct conflict with *Kunin*.

The Memorandum Opinion does not apply the doctrine of *contra proferentem*, but centers on whether there is "a reasonable interpretation of the Policy that favors Allstate" (Appendix B, p. B-4). The Memorandum Opinion examines the word "loss" and finds in ALLSTATE's favor because:

> "Read in isolation, 'loss' could reasonably refer to either 'sickness' or 'expense'; the term is itself ambiguous. But precisely because of its ambiguity, it dose [sic] not conflict with the provisions that preclude vesting." (Appendix B, p. B-10).

Finally, the Memorandum Opinion dismisses the weight of authorities dealing with insurance policies containing "lifetime" benefits and states that it adopts *Sonneman v. Blue Cross and Blue Shield of Minnesota*, 403 N.W.2d 701 (Minn. Ct. App. 1987). Aside from the fact that *Sonneman* is contrary to the weight of authority, the Memorandum Opinion fails to distinguish or discuss that in *Sonneman* the insurance company did not act unilaterally to terminate or modify the policy. The State, acting on behalf of its employees, with bargaining power equal to or greater than Blue Cross and Blue Shield, negotiated a reduction in certain benefits in

exchange for increased benefits for the majority of its beneficiaries.

The criteria in interpreting insurance policies under ERISA should not be whether there is a reasonable interpretation of the Policy that favors the insurance carrier, but rather whether there is a reasonable interpretation of the Policy that would provide coverage. The Memorandum Opinion does not deal with the rule of *contra proferentum* set forth in *Kunin* which would require coverage because the terms "lifetime," "loss," and "while insured" are ambiguous, at best, and made the Policy susceptible to a reasonable interpretation that there is coverage after termination for illnesses incurred prior to termination. This Court should clarify that under ERISA the rule of *contra proferentem* is to be applied as federal common law in the construction of those insurance policies susceptible to more than one interpretation.

The Memorandum Opinion is also in direct conflict with the decision rendered in *Houghton v. American Guarantee Life Ins. Co.*, 692 F.2d 289 (3rd Cir. 1982). In *Houghton* the policy also used, but did not define, the term "loss." The *Houghton* court analyzed the meaning of the term "loss" in reference to the clause "while this

policy is in force." The *Houghton* court held the undefined term "loss" to be ambiguous and that the clause "while this policy is in force" could equally refer to "injury" and "sickness" or the term "loss." Therefore, the *Houghton* court found that the insured was entitled to benefits after policy termination for an illness that arose while the policy was in force:

> "Thus, the most crucial term in the policy, 'loss,' is left undefined. Additionally, the subsidiary clause 'while this policy is in force' which appears both in the 'injury' and 'sickness' definition could just as readily be construed as modifying the terms 'sickness' and 'injury' rather than the term 'loss' -- a construction urged upon us by AGLIC. If so interpreted, then benefits would be payable when an injury or sickness occurred at any time during the term of the policy with no limitation as to when such benefits would terminate." *Houghton*, *supra*, at 293.

The Memorandum Opinion in this case admitted that the term "loss" was ambiguous, yet held, "But precisely because of its ambiguity, it does not conflict with the provisions that preclude vesting" (Appendix B, p. B-10).

The court apparently was not concerned that had ALLSTATE used the defined term "Eligible Expense" in place of the word "loss" there would be no ambiguity. The Memorandum Opinion fails to explain why ALLSTATE used the broader undefined term "loss." Finding the same ambiguity, the *Houghton* court ruled that the policy should be read in favor of the insured and found coverage.

The inconsistent rulings evidenced by the two Circuit courts' rulings should be resolved. It is of national importance that there be a uniform rule in interpreting ERISA contracts. Will the rule of *contra proferentem* apply, as in *Kunin* and *Houghton*, or will the federal courts sail through uncharted waters applying a myriad of standards ranging from the rule of *contra proferentem* to interpretations supporting any position taken by an insurance carrier if there is a reasonable interpretation of the policy that can be found to favor the carrier? This Court should grant the petition so that it may rule that the doctrine of *contra proferentem* applies under ERISA in the interpretation of health insurance policies.

III. 29 U.S.C. §1144(b)(2)(A) SAVES STATE LAWS REGULATING INSURANCE FROM ERISA PREEMPTION. THEREFORE, IN CALIFORNIA UNDER THE DECISIONAL RULING OF *FIELDS V. BLUE SHIELD OF CALIFORNIA*, AN INSURED'S RIGHT TO COVERAGE IN A HEALTH POLICY VESTS AND BECOMES FIXED AT THE TIME THE ILLNESS IS INCURRED.

AUL acknowledges that ERISA preempts all state laws regulating employee welfare benefit plans. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 95 L.Ed.2d 39, 107 S.Ct. 1549 (1987). However, under 29 U.S.C. §1144(b)(2)(A), state laws regulating insurance are not preempted, including decisional laws of the states. 29 U.S.C. §1144(c)(1). Thus, to the extent an employee welfare benefit plan is funded through insurance, state law regulating insurance governs. *FMC v. Holliday*, 498 U.S. 52, 112 L.Ed.2d 356, 111 S.Ct. 403, 411 (1990). Regulation of the substantive content of insurance contracts is thus saved from ERISA preemption whether it occurs by statute or court decision.

The Memorandum Opinion overlooked the ERISA saving clause and by this oversight, the court was unable to render a decision based upon the correct applicable law. AUL contended on appeal that California decisional

law, specifically *Fields v. Blue Shield of California*, 163 Cal.App.3d 570, 209 Cal.Rptr. 781 (1985) regulates coverage in the present action. The Memorandum Opinion fails to deal with this issue. The Opinion merely at the outset states: ". . . interpretation of ERISA insurance policies is governed by a 'uniform federal common law.'" (Appendix B, pp. B-2, B-3). This general statement does not, however, deal with the question of whether *Fields* is decisional state law regulating insurance and applicable to the present case. If *Fields* is applicable, as California decisional law regulating insurance, a different result is probable.

There are limitations imposed upon the ERISA saving clause such that it only applies to regulations which meet the criteria set forth in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987). In *Pilot Life*, the Court adopted a two-part test. First, the Court looked to a common-sense view of the language of the saving clause. *Pilot Life*, *supra*, 481 U.S. at 48. Second, the Court used the case law developed under the *McCarran-Ferguson Act*, 15 U.S.C. §1011, et seq., to determine whether the particular regulation falls under the business of insurance for purposes of the *McCarran-Ferguson Act*. In doing so, the Court applied a three-part test: (1) whether the

practice has the effect of transferring or spreading a policy holder's risk, (2) whether the practice is an integral part of the policy relationship between the insurer and the insured, and (3) whether the practice is limited to entities within the insurance industry. *Pilot Life*, *supra*, 481 U.S. at 48-49.

As to the common-sense approach to the language of the saving clause, "the saving clause retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefit plans." *FMC v. Holliday*, 498 U.S. 52, 112 L.Ed.2d 356, 111 S.Ct. 403, 411 (1990). In conformity with this Supreme Court decision, California state law regulating insurance governs this matter because Grayce Aul and related parties reside and are domiciled in California, the policy was purchased in California by a California Corporation for the benefit of California workers and their dependents, Grayce Aul developed her illness in California, and she received all of her medical treatment in California. No other state has any interest in any aspect of this dispute.

In California, the opinion rendered in *Fields v. Blue Shield*, 163 Cal.App.3d 570, 209 Cal.Rptr. 781 (1985) controls. *Fields* requires that health insurance benefits

cannot be diminished or terminated if an insured event occurs while the policy is in force. This is precisely the kind of regulation covered by the saving clause because, no matter what other states may allow or require, California requires that benefits under a health insurance policy are fixed when an insured develops a covered illness. The actual policy may provide for extremely limited coverage as to the illnesses covered or the dollar amount, but whatever the benefits are, they cannot be changed after the insured illness occurs.

Since ERISA neither prohibits nor requires vesting in welfare plans, each state may act upon the issue as it deems appropriate. Some states require vesting, and others do not. ERISA does not require uniformity in the substantive provisions of welfare benefit plans. As the Court stated in *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724, 85 L.Ed.2d 728, 747, 105 S.Ct. 2380 (1985):

> "We are also aware that appellants' construction of the statute would eliminate some of the disinformities currently facing national plans that enter into local markets to purchase insurance. Such disinformities, however, are the inevitable result of the Congressional decision to 'save' local

insurance regulation."

The *Fields* rule, being a decision within the statutory definition of a saved law under 29 U.S.C. § 1144(c)(1), controls the case at bar. ALLSTATE may not change policy coverage for an illness that occurred prior to the date the Policy was terminated.

CONCLUSION

The interpretation of health insurance contracts under ERISA is an important national issue affecting millions of American workers and their dependents. The question of whether beneficiaries who have been promised "lifetime" benefits have vested rights if they become ill while their health insurance policy is in force is a question that should be affirmatively settled by this Court. The issue of contract interpretation under ERISA and the application of the rule of *contra proferentem* is equally important. Finally, this Court should affirm the rights of a state to regulate the sale and content of insurance polices sold within its jurisdiction.

Wherefore, for all the foregoing arguments and

reasons, petitioners respectfully submit that the petition for certiorari should be granted.

Respectfully submitted,
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APPENDIX A

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 90-56145

D.C. No. CV-89-5449-WDK

FILED

July 15, 1992

Cathy A. Catterson, Clerk

U.S. Court of Appeals

GRAYCE AUL,
Individually and as
representative of AUL Pipe &
Tubing, Inc. Employee Welfare
Benefit Plan

Plaintiff-Appellant

v.

ALLSTATE LIFE INSURANCE COMPANY
AND OLD KENT BANK AS TRUSTEE
OF THE FIRST INSURANCE TRUST

Defendant-Appellee

ORDER

Before: BEEZER, HALL, and TROTT, Circuit Judges.

The panel has voted to deny appellant's petition for rehearing and to reject the suggestion for rehearing en banc.

The full court has been advised of the suggestion for rehearing en banc and no active judge has requested a vote on whether to rehear the matter en banc. Fed. R. App. P. 35.

The petition for rehearing is denied and the suggestion for rehearing en banc is rejected.

APPENDIX B

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 90-56145

D.C. No. CV-89-5449-WDK

FILED

January 22, 1992

Cathy A. Catterson, Clerk
U.S. Court of Appeals

GRAYCE AUL,
Individually and as
representative of AUL Pipe &
Tubing, Inc. Employee Welfare
Benefit Plan

Plaintiff-Appellant

v.

ALLSTATE LIFE INSURANCE COMPANY
AND OLD KENT BANK AS TRUSTEE
OF THE FIRST INSURANCE TRUST

Defendant-Appellee

MEMORANDUM*

Appeal from the United States District Court for the Central District of California, William D. Keller, District Judge, Presiding, Argued and Submitted May 8, 1991, Pasadena, California

Before: BEEZER, HALL, and TROTT, Circuit Judges.

Appellant Grayce Aul appeals from the district court's grant of summary judgment to Appellee Allstate in Aul's suit to obtain continuing medical benefits under a policy terminated by Allstate. The district court had jurisdiction under 28 U.S.C. § 1331 and 29 U.S.C. § 1132(e). This court has jurisdiction pursuant to 28 U.S.C. § 1291. We affirm.

I

As a preliminary matter, there is some dispute among the parties as to what law applies. Aul would have this court apply California law, while Allstate would have it apply Illinois law. We reject both positions. In *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1441 (9th Cir.

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*This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by 9th Cir. R. 36-3.

1990), this court held that the interpretation of ERISA insurance policies is governed by a "uniform federal common law." In developing a federal common law to govern ERISA suits, federal courts should borrow "from state law where appropriate, and [be] guided by the policies expressed in ERISA and other federal labor laws." *Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1502 (9th Cir. 1985).

II

This court reviews a district court's grant of summary judgment *de novo*. *International Brotherhood of Electrical Workers, Local 47 v. Southern Cal. Edison Co.*, 880 F.2d 104, 105 (9th Cir. 1989). In doing so, it must determine whether, viewing the evidence in the light most favorable to the party against whom summary judgment has been granted, there is any issue of material fact and whether the moving party is entitled to judgment as a matter of law. *Arizona Laborers Local 395 Health and Welfare Trust Fund v. Conquer Cartage Co.*, 753 F.2d 1513, 1515 (9th Cir. 1985). "When the meaning of an agreement is ambiguous on its face and contrary inferences as to intent are possible, an issue of material fact exists for which summary judgment ordinarily is inappropriate." *International Brotherhood of Electrical*

Workers, 880 F.2d at 107 (citing *Arizona Laborers*, 753 F.2d at 1517-18).

III

In determining whether or not an insurance contract is ambiguous, this court will interpret its terms "'in an ordinary and popular sense as would a [person] of average intelligence and experience.'" *Evans*, 916 F.2d at 1441 (quoting *Allstate Insurance Co. v. Ellison*, 757 F.2d 1042, 1044 (9th Cir. 1985)). The court should "examine[ ] the contract as a whole and if, on the face of the contract, two reasonable and fair interpretations are possible, an ambiguity exists." *Evanston Insurance Company v. Fred A. Tucker & Co. Inc.*, 872 F.2d 278, 279 (9th Cir. 1979). The court will "'not create ambiguity where none exists.'" *Evans*, 916 F.2d at 1441. And if "'a reasonable interpretation favors the insurer and any other interpretation would be strained, no compulsion exists to torture or twist the language of the policy.'" *Id.*

There is no doubt that there is a reasonable interpretation of the Policy that favors Allstate. The Policy includes a broad description of the expenses it covers that cannot be interpreted to include expenses

incurred after the Policy is terminated. It states: "The Medical Benefit is paid for Eligible Expense [sic] incurred for an Injury or Sickness while insured." And it defines an "Eligible Expense" as an expense "incurred for an Injury or Sickness while insured." [ER 45-46]. We are not persuaded by Aul's suggestion that in both instances "while insured" refers to "Injury or Sickness"; we think it is clear enough that "while insured" refers to "Eligible Expense." Both provisions plainly refer to *expenses incurred* while insured, not *expenses arising from a sickness incurred* while insured. This reading is supported by the clause providing that an "'Expense' is deemed incurred on the date the service or supply is furnished." [ER 55]. If the Policy covered expenses incurred after termination, there would be no reason to specify the date on which an expense is incurred.

This interpretation is consistent with the Policy's "EXTENSION OF BENEFITS" provision. That provision sets forth limited circumstances under which a person may obtain benefits under the Policy even though the policy has been terminated. It states that Allstate will pay the Medical Benefit after the person's insurance ends if the person is totally disabled at the time the Policy is terminated and at the time the expense is incurred, the expense is directly related to the disability, and the

expense is incurred within one year of the termination. [ER 48] If, as Aul claims, the Policy vested benefits, there would be no reason to include the "EXTENSION" provision because every expense it covers would be covered by vesting. In other words, the provision would be superfluous.

Aul, while conceding that there would be some overlap between the "EXTENSION" provision and vesting, argues that the provision would not be rendered entirely superfluous by vesting because there is a narrow category of injuries that would not become vested but would be subject to the "EXTENSION" provision. Aul's argument, however, merely begs the question of why, if it were Allstate's purpose to extend benefits for expenses not covered by vesting, it did not write the provision so that it just covered those expenses instead of writing a provision so broad that it overlapped with vesting. It also begs the question of why Allstate would expressly provide coverage for this narrow category of injuries but not expressly provide for vesting. The reasonable interpretation of the Policy is that the "EXTENSION OF BENEFITS" provision entirely defines the insured's rights to benefits after the Policy has been terminated.

Considered together, these provisions would appear

to preclude vesting. But Aul points to other aspects of the Policy that she claims vested her rights to benefits for any illness she contracted prior to the termination of the Policy. At the very least, she argues, these provisions cast doubt over those provisions of the Policy that preclude vesting, creating an ambiguity.

The first provision to which Aul points is contained in the Certificate of Coverage. The Certificate sets forth the maximum benefit the insured may receive under the Policy's schedule of benefits. At the time Allstate terminated the Policy, the schedule of benefits provided: "MEDICAL MAXIMUM": $1,000,000 DURING AN INSURED PERSON'S LIFETIME." Aul argues that "[a] reasonable interpretation of the Certificate is that if an insured contracts an illness while the Policy is in force, he or she has a right to lifetime benefits, regardless of what Allstate does with the Policy thereafter." Aul directs our attention to several state court decisions that have held that a policy's use of the phrase "lifetime maximum" either vests the insured's benefits or at least creates an ambiguity in a policy that elsewhere purports to limit benefits. *See Crum-Vanlandingham v. Blue Cross Health Services*, 734 S.W.2d 266 (Mo. Ct. App. 1987); *Fields v. Blue Shield of California*, 209 Cal. Rptr. 781 (Cal. Ct. App. 1985);

Danzig v. Dickman, 434 N.Y.S.2d 217 (1980).

We decline to follow these courts and instead adopt the position of the Minnesota Court of Appeals in *Sonneman v. Blue Cross and Blue Shield of Minnesota*, 403 N.W.2d 701 (Minn. Ct. App. 1987). That court held that use of the term "lifetime" does not manifest any intention to vest the insured's benefits. Like Aul's Policy, the policy at issue in *Sonneman* contained an "Extended Coverage" provision. The Minnesota court concluded that at least where a Policy contains such a provision, interpreting the term "lifetime" to vest the insured's rights would be unreasonable because it would render the "Extended Coverage Provision" superfluous. *See id.* at 706. We agree.

At oral argument, Allstate offered a plausible reason for its use of the word "lifetime." It explained that if a person leaves the plan and later returns, she does not start with a fresh benefits package; the benefits available to her are whatever is left of the $1,000,000 she had the first time around. This explains why the language "DURING AN INSURED'S LIFETIME" appears in the amended Certificate, with the $1,000,000 maximum, but not in the original Certificate, which provided for an "UNLIMITED" maximum; the word "lifetime" could in

no way limit an "unlimited" benefit.

Aul also argues that the "LIMITATIONS" section of the Policy implies the vesting of benefits for sicknesses incurred while the Policy is in force. That section sets forth twenty-one types of injury and medical care the Policy does not cover. And while "pre-existing" conditions are among these "LIMITATIONS," post-termination expenses incurred for sickness or injury contracted during the lifetime of the Policy are not. Aul argues that if Allstate intended to preclude vesting, post-termination expenses would have been listed among the "LIMITATIONS." The argument is not without merit, but the omission of post-termination expenses does not create an ambiguity because it was unnecessary for Allstate to list those expenses among the "LIMITATIONS." As explained above, the Policy explicitly limits benefits to expenses incurred while the Policy is in effect, and the "EXTENSION" provision defines the sole exception to that general rule. Those provisions render a vesting limitation superfluous. Consistent with this analysis, each of the express "LIMITATIONS" refers to an expense *incurred while the policy is in effect*. [*See* ER 49-50].

Finally, Aul points to the provision in the section of

the Policy entitled "TERMINATION OF INSURANCE." It states: "The end of insurance will not affect any claim made for a *loss* that took place while the insurance was in force." [ER 38 (emphasis added)]. Aul concludes that "loss" must refer to a sickness or injury that occurred while the policy was in effect. But Allstate responds that "loss" refers not to sickness but to "eligible expense." Read in isolation, "loss" could reasonably refer to either "sickness" or "expense"; the term is itself ambiguous. But precisely because of its ambiguity, it dose[sic] not conflict with the provisions that preclude vesting. Read in light of the Policy's express limitation on the payment of medical benefits and the "EXTENDED COVERAGE" provision, the ambiguity disappears and it becomes clear that "loss" refers to "expense." Thus the "TERMINATION" provision does not conflict with other portions of the Policy and does not render the Policy ambiguous.

IV

Because we conclude that the Policy unambiguously precludes the vesting of benefits, the decision of the district court is AFFIRMED.

APPENDIX C

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

Case No. 89-5449 WDK (Ex)

FILED

August 30, 1990

ENTERED

August 31, 1990

Clerk, U.S. District Court

Central District of California

GRAYCE AUL, Individually
and on Behalf of All Others
Similarly Situated,

Plaintiff,

v.

ALLSTATE LIFE INSURANCE
COMPANY, a corporation,
and DOES 1 through 100,
inclusive,

Defendants.

ORDER re DEFENDANT'S MOTION TO DISMISS OR FOR SUMMARY JUDGMENT

The Court sought to focus the material disputes in this case by inviting defendants to file a dispositive motion. Before the Court is the motion of Allstate Insurance Company to dismiss the Complaint or for Summary Judgment. The insurance contract and its interpretation, supported by affidavits, are central, and the motion shall be treated as one for summary judgment. *See* Fed. R. Civ. P. 56(b).

For the reasons which follow, defendant's motion is GRANTED.

BACKGROUND

1. Allstate issued an insurance policy to the First Insurance Trust. In or about April 1981, plaintiff Aul Pipe & Tubing, Inc., applied to the First Insurance Trust to participate in the trust and to provide group medical expense benefits to its employees. The application was approved and coverage became effective for covered employees at Aul Pipe & Tubing on May 1, 1981.

2. During the pendency of the policy, plaintiff Grayce Aul, a beneficiary of the policy, began receiving

liver treatment and made claims for expenses in connection with that treatment. The treatment began in 1981 and has continued until the present date.

3. On approximately February 17, 1989, Allstate notified plaintiff and plaintiff's employer that the Group Policy would be terminated on May 1, 1989, at 12:01 a.m. On May 1, 1989, the policy was terminated.

4. In December, 1989, Grayce Aul underwent a liver transplant incurring approximately $250,000 in medical and hospital bills. These expenses were by stipulation incurred after termination of the policy. *See* Decl. of Henry Aul at Para. 8; Decl. of Grayce Aul at Para. 5.

5. Allstate denied responsibility for these claims on the basis of the termination of the policy.

6. Plaintiff, suing on behalf of herself and all those similarly situated, claims that persons who contract an illness during the term of the policy are "vested," and that expenses precipitated by that illness are covered by the insurer notwithstanding termination of the policy.

DISCUSSION

7. The Court by an earlier order found the insurance in question to be a plan governed by the Employee Retirement Income Security Act, or ERISA. 29 U.S.C. § 1001 *et seq*. It is, the Court held, an "employee welfare benefit plan," as defined by ERISA, 29 U.S.C. § 1002(1). As a consequence of this finding, the law of "ERISA, rather than state contract law," controls. *Kunin v. Benefit Trust Life Ins.*, No. 88-6573, slip. op. at 7957 (9th Cir., July 27, 1990).

8. As indicated in *Kunin*, *supra*, this does not mean that State law is immaterial. Indeed, State law may well provide the rule of decision if there is an indication that Congress left the area open, did not provide a federal rule, or

> because the incorporation of state law into the federal common law is 'appropriate as a matter of judicial policy under the three-part test established by *Kimbell Foods*.' *Madan Corp. v. C.G.C. Music, Ltd.*, 804 F.2d 1454, 1458 (9th Cir. 1986).

Id. at 7957; *see also id*. at n. 8; 29 U.S.C. § 1144(a). Thus the Court must examine whether federal law on its

fact, or state law interstitially, provides a basis for plaintiff's claims.

Vesting

9. Plaintiff contends that an insured's rights "vest" in circumstances like these, and to that end seeks guidance from the laws of the several states, but most notably California. *See* Plaintiff's Opposition to Summary Judgment at 22-25. Plaintiff urges adoption of California's law. *Id.*

10. First, ERISA does not require vesting. The statute itself draws distinctions which eliminate the argument that it does. However, ERISA does not preclude vesting either. Were it founded upon the contract itself, vesting might be appropriate.

ERISA

11. ERISA does not incorporate a rule of vesting for employee welfare benefit plans. Under ERISA, there is a distinction between pension plans, 29 U.S.C. § 1002(s), and welfare plans, 29 U.S.C. § 1002(1). As to pension plans, Congress explicitly provided that they have the attributes of a vested plan. *See* 29 U.S.C. §

1101-04, 1051-61, 1081-66, 1053(a). There is no equivalent requirements for "employee welfare benefit plans." They are, indeed, excluded from the requirements to which pension plan are subject. 29 U.S.C. § 1051(1).

12. The Supreme Court and the Ninth Circuit have both recognized the distinction made by Congress between welfare and pension plans. In determining that a vacation benefits plan is not covered by ERISA, the Supreme Court stated:

> Finally, such an interpretation would also displace the extensive state regulation of vesting, funding, and participation rights of vacation benefits; because ERISA's vesting and funding requirements do not apply to welfare benefit plans . . . .

Massachusetts v. Morash, ___ U.S. ___, 109 S.Ct. 1668, 1675 (1989). The Ninth Circuit, as cited by defendants, also recognizes the distinction.

> ERISA . . . expressly exempts employee welfare benefit plans from the sections concerned with vesting and accrual. 29 U.S.C. § 1051(1). While ERISA, in 29

> U.S.C. § 1322, also guarantees the payment of "all nonforfeitable benefits," this protection is applicable only to pension, stock bonus, or profit-sharing plans. 29 U.S.C. § 1321(a); 26 U.S.C. § 401(a). There is no language in ERISA which provides for the accrual of welfare benefits or guarantees that such benefits are vested or nonforfeitable. *Turner v. Local No. 301, Int'l Bhd. of Teamsters*, 604 F.2d 1219, 1225 n. 5 (9th Cir. 1979).

West v. Greyhound Corp., 813 F.2d 951, 954 (9th Cir. 1987). A review of the reticulated statutory scheme shows that Congress, had it intended to, could have set forth a vesting requirement for welfare plans, but did not. Consequently, it must be concluded that Congress did not intend to require that such plans vest.

13. The Court rejects any reading of ERISA's statute requiring that welfare plans vest. To so require would subvert the desire of Congress not to incorporate the vesting requirements for welfare plans. *Massachusetts v. Morash*, 109 S.Ct. at 1675 (bringing plan within coverage of ERISA would eliminate vesting privileges).

14. The next contention is that, although ERISA's statute does not require vesting, the common law of

contract interpretation which surround ERISA does, or should. To this end plaintiff looks to the law of California and urges that it be adopted as a uniform federal rule.

California Law

15. California's rule which interprets a right of vesting in a medical benefit contract is expressed in *Fields v. Blue Shield of California*, 163 Cal.App.3d 57, 209 Cal.Rptr. 781 (1985). The Court in *Fields* held that an insured's rights "vest" when a disability or injury precipitating continued expenses occurs during the coverage period.

> "In other words, once liability has attached under a group policy -- that is, after the happening of the even insured against -- cancellation or modification of the master policy is ineffective to preclude recovery by the employee or his beneficiary as provided by the original policy, irrespective of whether the policy is contributory or noncontributory."

Fields, *supra*, 163 Cal.App.3d at 585-86, 209 Cal.Rptr. at 790, quoting Annot. 68 A.L.R. 2d 249, § 17, 278-29.

16. There is certainly an economic rationale for this position. An insurer sells its ability to assume risk. If a risk matures into a liability, the insurer's ability to forswear responsibility mocks the transaction. This is not to say that an insurer could not, under a vesting rule, terminate its coverage. But the decision to terminate coverage operates only prospectively, relieving the insurer of having to assume any further risk that catastrophe will befall the insured in the future.

17. Thus, it is said in *Fields*:

> A valid cancellation or modification of a group policy . . . does not have the effect of releasing the insurer from liability which accrued prior thereto by reasoning of the happening of the contingency insured against.

Fields, 163 Cal.App.3d at 585, 209 Cal.Rptr. at 790. As a consequence of this reasoning, the Court in *Fields* sought to protect the expectation of the insured.

18. But it is unclear whether *Fields* holds that medical insurance contracts vest as a matter of law, or that the particular contract in issue gave rise to a vested right. *See infra* at note 1. Plausibly, the right in *Fields*

was founded upon the language of the contract. Without the rule, the Court said, the language in the contract guaranteeing "a lifetime maximum coverage" would be meaningless. Thus, to give meaning (and to protect the reasonable expectation) the Court found vesting. Quoting the New York appellate Court in *Danzig v. Dikman*, 78 A.D.2d 303, 434 N.Y.S.2d 217, *aff'd* 53 N.Y.2d 926, 440 N.Y.S.2d 925, 523 N.E. 2d 402 (N.Y. Ct. App. 1981), *Fields* said:

> Parenthetically, the existence of a lifetime maximum (whether limited or unlimited) discloses an awareness of the part of the insurer and all interested parties that an illness or condition might well continue indefinitely beyond any one contract term and, indeed, persist for the lifetime of an individual subscriber or his or her beneficiary.

Consequently, the *Fields* Court reasoned, the expectation of a subscribing insurer is that his coverage is limited only by the maximum amount and his own need during his lifetime. But the disposal of matter in *Fields* would seem to imply as a matter of law that rights vest; they cannot be terminated unilaterally by an insurer after the insured has incurred the disability precipitating the expenses.

19. The holding in *Fields* that vesting is required would be an extension of the federal law.[1] A holding that vesting may be contracted by the parties would not be. Nor, moreover, would it be an extension of federal law to enforce an insured's expectation of vesting, if it were based on a fair reading of an ambiguous contract. The rule -- that ambiguities be read in favor of the insured, *contra proferentum* -- has been recently adopted as the governing federal rule in ERISA cases. *Kunin v. Benefit Trust Life Insurance Co.*, No. 88-6573, slip op. at 7956-61 (9th Cir., July 27, 1990).

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[1] The *Fields* Court called the policy "ambiguous on its face" and said that the limitations in the policy conflicted with the "lifetime maximum". *Id.* at 163 Cal.App.3d at 584, 209 Cal.Rptr. at 789. But the Court did not remand for a factual determination of the parties' intent. Instead, the Court went on to state that the "language [giving a lifetime maximum] evidence a clear contractual intent of Blue Shield to provide for nervous or mental illness which might persist for the lifetime of an insured; . . . ." *Id.*, 163 Cal.App.3d at 585, 209 Cal.Rptr. at 709. Then, the Court ruled that vesting applies to these contracts (without extrinsic proof of intent) as a matter of law. *Id.* ("These benefits . . . became vested as a matter of legal and contractual right under the language of the 1975 plan").

Consequently, the *Fields* ruling must be analyzed in two ways. It is both precedent for the rule that medical insurance benefit contracts vest as a matter of law, or, that they may vest if the parties so intend. The second proposition is acceptable, though it does not appear to be the basis [of] the opinion in *Fields*. To the extend[sic] that the plaintiff urges the former proposition, its adoption into federal law would be novel and must be analyzed as in *Kunin*.

20. For purposes of this analysis, however, *Fields* should be construed in the stricter sense: that it *requires* medical contracts to vest. Plaintiff's suggestion that federal law adopt this holding must be scrutinized.

Federal Rule of Interpretation

21. Shall the *Fields* rule prevail as the federal rule of interpretation; that is, does language promising "lifetime maximum coverage" subject the contract to a reading that creates a right to vested benefits[ ]

22. The first reason why such a rule should not be engrafted into federal law has been illuminated. ERISA's thoroughly complex scheme has set forth which plans vest and which do not. While not barring contractually created vesting rights, ERISA does not encourage a federal rule which would imply one liberally. So there can be no presumption that medical coverage contracts provide such a right; the analysis is at best in equipoise.

23. Second, the rule of contract interpretation for ERISA does not require that an insured's unilateral expectation prevail. As stated in *Kunin*, the rule of *contra proferentum* requires resort to the fair

interpretation of the insured "after applying the normal principles of contractual construction." *Kunin*, slip op. at 7956. Thus, if the contract read as a whole, or reasonably read to give effect to all parts, does not provide ground for a vesting right, there is none.

24. Third, *Kunin* implicitly adjures that a common law rule be adopted as a federal rule only where there is some consensus. Here, the *Fields* approach, which goes beyond the language of the contract to find a medical benefit vesting right (heretofore reserved for accident and life is far from a universal notion. The rule of "contract interpretation" employed there goes far beyond *Kunin*'s reasoning in adopting the rule of *contra proferentum*. *Kunin* adopted *contra proferentum* because it (1) is the rule in all fifty states and the District of Columbia, slip op. at 7958, and (2) because it made sense in light of the adhesive nature of insurance contracts. Slip op. at 7959. Neither of these justifications exist here.

25. *Fields* applied a general vesting rule, applicable to accident and occurrence insurance, to medical insurance. As indicated in defendant's brief, this extension has not been followed in other jurisdictions. *See* Defendant's Motion for Summary Judgment at 32-32[sic]. The distinction between accident and medical

policies limits vesting; the distinction is longstanding. *See Bartulis v. Metropolitan Life Ins. Co.*, 72 Ill. App.2d 267, 218 N.E.2d 225 (1966); 75 A.L.R.2d 876 (1961) (accident policies provide for vested benefits when loss precedes termination). Indeed, even in California, the *Fields* ruling has not been cited as authority for its sweeping proposition. *See Rogers v. Prudential Ins. Co.*, 267 Cal.Rptr. 499, 501 (Cal. App.4 Dist. 1990) ("lifetime benefits" may play role in policy which is ambiguous because contract is destroyed); *In re Marriage of Higinbotham*, 203 Cal.App.3d 322, 334, 249 Cal.Rptr. 798, 804 (1988) (failure to raise legal issue at trial court does not necessarily preclude appellate review of same); *Hartenstine v. Superior Court*, 196 Cal.App.3d 206, 216, 241 Cal.Rptr. 756, 763 (1987) (collateral estoppel issue); *Cal-Farm Ins. Co. v. Tac Exterminators*, 172 Cal.App.3d 564, 579, 218 Cal.Rptr. 407, 415 (1985) ("the insured has a duty to read the policy"); *State Farm Mut. Auto Ins. Co. v. Khoe*, 884 F.2d 401, 408 (9th Cir. 1989) (duty to read policy insufficient to bind party to unusual or unfair language unless it is brought to attention of party and explained); *Allstate Insurance Co. v. Fibus*, 855 F.2d 660, 663 (9th Cir. 1988) ("an insurance company is bound by a greater coverage in an earlier policy when a renewal policy is issued but the insured is not notified of the specific reduction in

coverage"); *see Fields*, 163 Cal.App.3d at 591-602, 209 Cal.Rptr. at 794-801 (Butler, J., dissenting). Thus, the rule that medical benefits vest is not universally accepted and could hardly be invoked as a uniform federal rule. *See Kunin*, slip op. at 7957.

26. Furthermore, the rule is not one that could be sensibly established to fill the interstices of the existing statutory scheme. Its adoption would render meaningless legislation intended to extend benefits after termination. This legislation exists at both the State, *see e.g.*, Cal. Ins. Code §§ 10128.2, 12692, and Federal level. *See*, 29 U.S.C.A. §§ 1161-1168 (providing for continuation coverage on certain health and medical plans). Therefore, the federal common law of ERISA cannot be construed to require that health and medical contracts, without more, vest; if it did it would devour the ERISA codification itself.

27. Nevertheless, as stated earlier, this does not constrain the parties from contracting to create such right. ERISA does not forbid vesting, nor does the reluctance to adopt California's *Fields* ruling require the Courts to eschew every vesting argument that is founded on the language of the agreement. As plaintiff indicates in her brief, the option remains open to the parties.

> ERISA requires that '[e]very employee benefit plan . . . be established and maintained pursuant to a written instrument.' 29 U.S.C. § 1102(a)(1). Through those instruments, the parties are free to subject such welfare benefits to vesting requirements not provided by ERISA, or they may reserve the power to terminate such plans. As the Sixth Circuit has stated in *Hansen v. White Farm Equipment*, 788 F.2d 1186 (6th Cir. 1986), 'the parties may themselves set out by agreement or by private design, as set out in plan documents, whether retiree welfare benefits vest, or whether they may be terminated.' [ ]

Ryan v. Chromalloy Am. Corp, 877 F.2d 598, 603 (7th Cir. 1989). The contract at issue must be examined.

The Contract of Insurance

28. The starting point is necessarily the insurance contract, and the contract alone. *Ryan*, *supra*. Plaintiff urges reference to advertisements and brochures, description of the plan and the like. These are relevant only upon a determination that the contract itself is ambiguous, in which instance extrinsic evidence has a role. *Bower v. Bunker Hill Co.*, 725 F.2d 1221, 1223-25 (9th Cir. 1985). Because, however, the contract clearly defines its own limitations and rights, and does not leave room for the vesting of medical benefits, resort to extrinsic evidence is unnecessary.

29. The Contract is attached as Exhibit F to Plaintiff's Memorandum of Points and Authorities in Opposition to Defendant's Motion for Summary Judgment. It is the Certificate of Insurance and by its own terms constitutes the entire contract. *See id.* at 25 ("The entire contract consists of: the group policy; the Policyholder's application; the Employer's application; and the Employees' applications, if any").

30. It is subdivided into six parts. They are (1) insuring provisions; (2) employee life insurance; (3) employee accidental death and dismemberment; (4)

comprehensive medical insurance; (5) general provisions; and (6) financial provisions. The three substantive areas of coverage are, then: life, accidental death and dismemberment, and comprehensive medical.

31. It is unambiguous from the face of the contract that the insurer can terminate individual's coverage. There is a section in the contract entitled "Termination of Insurance." That section provides that the coverage as a whole ends when, among other things, the group policy ends. *Id.* at 3 ("your insurance ends when . . . the group policy . . . ends"). Furthermore, the policy provides that it can be cancelled by the insurer:

> We may end the group policy on any premium due date after the first policy anniversary. To do this, we must give at least 60 days notice to the Policyholder.

Id. at 6. It is uncontested that the group policy ended on May 1, 1989, and that 60 days notice was provided.[2]

---

[2] Plaintiff's claim for breach of fiduciary duty based upon termination of the policy cannot stand. There is no breach when a party does what by contract it is entitled to do. The claim for breach of the duty could only survive if it were determined that Allstate terminated coverage wrongfully.

32. Plaintiff first sustains her argument for vesting on language at page 4-5 of the Contract, within the section relating to "termination of insurance." Plaintiff points to the last sentence of that provision, at page 6, which states that:

> The end of insurance will not affect any claim made for a loss that took place while the insurance was in force.

33. Plaintiff claims that this statement requires that the vesting rule which is ordinarily applicable to accident and life insurance be carried over to medical insurance. But this argument is not plausible in its context.

34. First as noted in paragraph 24, *supra*, there is a commonly applicable vesting rule to accident and life insurance policies which is not generally extended to medical insurance. Thus, the provision in the Contract -- that termination will not affect coverage for a loss that took place before termination -- applies to the life and accident insurance. The clause is in the section of the policy entitled "insuring provisions." These are generally applicable; there is no similar statement implying a right of vesting in the medical coverage section.

35. There is the same language at the foot of the subdivision entitled "Dependent's Insurance -- Medical Expense Insurance." This statement, standing alone, could give rise to an argument that a "loss" is an event which precipitates medical coverage and that expenses incurred after termination, due to the "loss," are covered. But read in context with the express limitations in the contract, that reading is improbable. The clause means that, notwithstanding the termination of insurance, you can still file claims for insurable expenses that occurred before termination, even if you file the claim after termination. Thus: the end of insurance will not affect and *claim* made for a loss that took place while the insurance was in force. This interpretation of the language is one that naturally flows from the words. Furthermore, it avoids plaintiff's reading, which would subvert the remainder of the limitations expressly stated in the policy.

36. The first of the specific provisions permitting termination appears at page 6. It states that:

> We [Allstate] may end the group policy on any premium due date after the first policy anniversary. To do this, We must give at least 60 days written notice to the Policyholder.

There is, of course, no question that Allstate could terminate the policy. The question is whether termination concludes coverage for expenses incurred after termination for injuries or illnesses which occurred before termination. The language of the contract says that coverage ends upon termination, but plaintiff contends that there is other language suggesting that medical benefits will continue after termination.

37. The pertinent language is in the section dedicated to "Comprehensive Medical Insurance." Therein, at page 12, the contract states:

> The Medical Benefit is paid for Eligible Expense incurred for an Injury or Sickness while insured.

Plaintiff contends that this statement means: coverage for any expense arising out of an injury incurred while insured. It does not say that, and other sections shed light on the proper interpretation.

38. At page 22, "Expense" is defined as:

> a charge a person is legally obligated to pay. "Expense" is deemed to be incurred on the date the service or supply is

furnished.

Thus, an "Expense incurred for an injury or sickness while insured" refers to the expense, not the injury. The definitions of "injury" and "sickness" do not speak of the time they were incurred; only medical expenses are incurred at a given time. If they are incurred during insurance, they are covered, regardless of termination.

39. To read it as plaintiff would like -- injury or sickness incurred while insured -- would invite an interpretive horror. When is a sickness incurred? Upon discovery, claim, treatment, symptoms? Are latent diseases incurred before detected? These questions are unanswerable in the abstract, so the policy looks to the date an expense is incurred.

40. This applies to plaintiff's reference to page 13, as well, which states:

> "Eligible Expense" means the following types of Expense incurred for an Injury or Sickness while insured. . . .

41. Even standing alone, there is nothing in these provisions to give rise to any ambiguity or suggestion

that rights to coverage vest under the comprehensive medical coverage of the policy. The conclusion is buttressed by review of the whole policy.

42. The language of the policy in dealing with "incurred expenses" is consistent. At page 15, the policy provides for extensions of benefits under certain circumstances for up to twelve months. Again, the focus is on expenses, and the timing is based on the date the expense is incurred. Furthermore, the fact that the policy provides for extensions expressly and carefully means that there is no general extension as would be required if rights vested. The extension would be swallowed up if the parties intended to create a right to vested medical benefits. But they did not, and their intention not to is clear on the face of the contract.

43. Alternatively, plaintiff contends that the policy itself requires that the *Fields* decision govern and that plaintiff's rights vest. This comes from a provision on page 26:

> CONFORMITY WITH THE LAW
>
> If any provision of the group policy or the Employer's Plan at time of issue is contrary to any law to which it is subject,

> the provision is changed to meet the law's minimum requirement.

The law which governs the contract here is federal law. *See* paragraph 7, *supra*. Federal law does not *require* that insurance policies provide for vested medical benefits. *See* paragraphs 10-13, 25-26. Therefore, there is nothing in this contract which is contrary to the law, and *Fields* is not incorporated by the clause.

44. While the foregoing analysis might seem to leave those who contract debilitating illnesses without coverage -- the argument being that those who are infirm are uninsurable in the marketplace -- the Conversion Privilege assures these people that they need not contend in that arena. The Conversion Privilege permits the beneficiaries of the group policy to apply for individual coverage "without proof of insurability." So the result that flows from this ruling is not so Draconian.

45. Finally, plaintiff seeks to continue the high maximum life benefit by recourse to the Conversion Privilege at page 19 of the Contract. The section provides that under certain conditions an employee whose group policy was terminated will be eligible to continue individual insurance without proof of insurability. The

terms of the insurance are not, as plaintiff urges, commensurate with those terms under the group policy, but "will be in accord with all state laws and regulations which apply." *Id.* at 20. There is no applicable state law requiring that the replacement or conversion policy be commensurate, only that it be provided with certain minimum coverage. *See e.g.*, Cal. Ins. Code § 12684.

CONCLUSION

ERISA's statutory scheme does not require that medical benefits insurance contracts provide their insured with vested privileges for expenses precipitated by injuries or sickness which occur while the insurance is in force. Furthermore, the *Fields* rule, to the extent it requires that such vesting be read into medical benefits contracts, does not provide the rule of decision under the federal common law of ERISA. It is both uncelebrated and inconsistent with the federal scheme. Finally, the contract itself does not suggest that those who are insured will receive continuing medical benefits after the termination of the contract. The termination, as the contract states, ends coverage. "Your insurance ends when ... the group policy ... ends." Thus, medical expenses incurred after termination, even if due to a condition existing before termination, are not covered

under the group policy.[3]

For the reasons stated, Defendant's motion for summary judgment is GRANTED IN FULL.

IT IS SO ORDERED.

/s/ WILLIAM D. KELLER, JUDGE
United States District Court

DATED August 30, 1990

---

[3] This is not intended to preclude coverage under the provisions of the contract for conversion, extension, or special privileges for Totally Disabled insureds.

APPENDIX D

ALLSTATE GROUP INSURANCE
Certificate of Coverage

[Non-Related Terms Omitted]

Account Number: 6412060S
Employer: AUL PIPE & TUBING
Address: Los Angeles, CA 90023
Employee: H AUL
Certificate Number: 357244767

SCHEDULE OF BENEFITS

MEDICAL MAXIMUM: $1,000,000 DURING AN INSURED PERSON'S LIFETIME

DEPENDENT MEDICAL EXPENSE INSURANCE CONVERAGE IS INCLUDED.

PREGNANCY COVERAGE: COMPLICATIONS OF PREGNANCY ONLY

THE CERTIFICATE OF COVERAGE, CERTIFICATE BOOKLET, AND ANY CERTIFICATE AMENDMENTS CONSTITUTE YOUR CERTIFICATE OF INSURANCE. REFER TO YOUR CERTIFICATE BOOKLET AND CERTIFICATE AMENDMENTS FOR BENEFIT DESCRIPTIONS, DEFINITIONS, LIMITATIONS AND EXCLUSIONS.

APPENDIX E

Excerpts From

ALLSTATE LIFE INSURANCE COMPANY
CERTIFICATE BOOKLET

TERMINATION OF INSURANCE

Employees' Insurance

Subject to the Continuance of Insurance provisions as listed in the Table of Contents, your insurance ends when the first of these events takes place:

- the date the group policy or the Employer's Plan ends;

- the date the group policy or the Employer's Plan is changed to end insurance for the class to which you belong;

- the month you are no longer in an eligible class, in which case insurance stops at the end of that month;

The end of insurance will not affect any claim made for a loss that took place while the insurance was in force.

Dependents' Insurance · Medical Expense Insurance

Subject to the Continuance of Insurance provision, a dependent's insurance ends when the first of these events takes place:

- the date your insurance ends;
- the date the group policy or the Employer's Plan is changed to end Dependents' Insurance;
- the month the dependent is no longer eligible for this insurance, in which case insurance stops at the end of that month;

The end of insurance will not affect any claim made for a loss that took place while the insurance was in force.

MEDICAL BENEFIT

The Medical Benefit is paid for Eligible Expense incurred for an Injury or Sickness while insured.

ELIGIBLE EXPENSE

Eligible Expense means the following types of Expense incurred for an Injury or Sickness while insured.

LIMITATIONS

4. taking part in a felony.

DEFINITIONS

'Expense' means a charge a person is legally obligated to pay. 'Expense' is deemed to be incurred on the date the service or supply is furnished. We apply 'Expense' in the order incurred.

CONFORMITY WITH THE LAW

If any provision of the group policy or the Employer's Plan at time of issue is contrary to any law to which it is subject, the provision is changed to meet the law's minimum requirement.

EMPLOYEE CERTIFICATES

We will provide a certificate for the Employer to deliver to each insured Employee. The certificate will:

- summarize the main features of the insurance;

APPENDIX F

Excerpts From

ALLSTATE'S ADVERTISEMENTS

MEDICAL COVERAGE

Broad Benefits that Provide Comprehensive Protection

No lifetime maximum limit!

Allstate Life Insurance Company Pays the Usual Expense Incurred . . .

- For hospital room and board up to the semi-private rate
- For professional services by a surgeon, physician, anesthetist, registered nurse, or licensed physiotherapist
- For services and supplies such as diagnostic X-ray and laboratory exams, prescription drugs, radiation therapy, blood transfusions, and other services and supplies.

APPENDIX G

DECLARATION OF KENNETH REICH IN SUPPORT OF MOTION FOR CLASS CERTIFICATION attached to POINTS AND AUTHORITIES IN SUPPORT OF MOTION OF PLAINTIFFS GRAYCE AUL AND AUL PIPE & TUBING, INC. AND HENRY AUL, AS ADMINISTRATORS OF THE AUL PIPE AND TUBING EMPLOYEE WELFARE BENEFIT PLAN TO CERTIFY ACTION AS A CLASS ACTION PURSUANT TO FEDERAL RULE OF CIVIL PROCEDURE 23

FILED

April 9, 1990

Clerk, U.S. District Court

Central District of California By Deputy

I, KENNETH REICH, declare as follows:

1. All facts set forth in this declaration are of my own personal knowledge. If called and sworn as a witness, I could and would competently testify to all facts set forth herein.

2. I am a staff writer employed by the Los Angeles Times. Last year I decided to write an article about Grayce Aul. I contacted Allstate Life Insurance

Company in reference to its cancellation of her group health insurance policy. I personally met with David McPherson, Executive Vice President for Administration for Allstate Life Insurance Company, and Robert Seiler, Senior Vice President and General Counsel of Allstate Life Insurance Company, in July, 1989, in Northbrook, Illinois. These gentlemen told me the following:

A. Allstate was cancelling approximately 14,000 separate employer small group policies sold throughout the United States.

B. There was an average of three individuals covered under each employer small group policy.

C. People who are insurable will not take conversion policies. Only the uninsurable will.

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct.

Executed on this 6th day of April, 1990, at Los Angeles, California.

/s/ KENNETH REICH

aul\appendix

Supreme Court, U.S.
FILED
NOV 12 1992
OFFICE OF THE CLERK

No. 92-629

IN THE
Supreme Court of the United States
OCTOBER TERM, 1992

GRAYCE AUL, Individually, AUL PIPE & TUBING, INC., as a Fiduciary of the Aul Pipe & Tubing, Inc. Employee Welfare Benefit Plan, and HENRY AUL, as an Administrator of the Aul Pipe & Tubing, Inc. Employee Welfare Benefit Plan,
Petitioners,
vs.
ALLSTATE LIFE INSURANCE COMPANY, and OLD KENT BANK, as Trustee of the First Insurance Trust,
Respondents.

PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Should this Court review the question whether, where an ERISA welfare benefit plan expressly limits medical expense benefits to those expenses incurred while the group insurance policy which funds the plan is in force, and where Congress has expressly limited the requirement of "vested" benefits to pension plans, plan participants have a "vested" right to "lifetime" benefits for expenses incurred subsequent to the termination of the policy and the expiration of any extend benefit period?

2. Should this Court review the question whether, as a matter of federal common law, ambiguities in an ERISA plan are to be construed under the rule of *contra proferentem*, where the plan at issue is not ambiguous?

3. Should this Court review the question whether state decisional law of interpretation of insurance policies is "saved" from ERISA preemption pursuant to ERISA's "saving" clause, 29 U.S.C. § 1144(b)(2)(A), as a "law of any State which regulates insurance," where the decision at issue not only does not reflect the law of the state in which it was decided, but is limited to interpretation of the specific insurance policy at issue in that case?

RULE 29.1 LISTING

1. Parents

Respondent Allstate Life Insurance Company is a subsidiary of Sears, Roebuck & Co. and of Allstate Insurance Company.

Respondent Old Kent Bank is a subsidiary of Old Kent Financial Corporation.

2. Subsidiaries

Allstate Insurance Company of Canada and Allstate Life Insurance Company of Canada are subsidiaries of Respondent Allstate Life Insurance Company.

Respondent Old Kent Bank has no subsidiaries.

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No. 92-629

In The
SUPREME COURT OF THE UNITED STATES
October Term, 1992

GRAYCE AUL, Individually, AUL PIPE & TUBING, INC., as a Fiduciary of the Aul Pipe & Tubing, Inc. Employee Welfare Benefit Plan, and HENRY AUL, as an Administrator of the Aul Pipe & Tubing, Inc. Employee Welfare Benefit Plan,
Petitioners,
vs.
ALLSTATE LIFE INSURANCE COMPANY, and OLD KENT BANK, as Trustee of the First Insurance Trust,
Respondents.

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

Respondents, Allstate Life Insurance Company ("Allstate") and Old Kent Bank, respectfully request that this Court deny the Petition for Writ of Certiorari seeking review of the Ninth Circuit's decision in this case. The decision is unpublished.

STATEMENT OF THE CASE

A. Nature Of The Case

Petitioners commenced this action as a purported class action claiming that Petitioner Grayce Aul, as representative of the purported class, and the purported class members are entitled to benefits under the group insurance policy at issue for medical expenses incurred by them *after* the termination of the policy by Allstate.

Petitioners were participants in employee welfare benefit plans funded by Allstate's policy which was issued to a multiple employer trust, the First Insurance Trust, to which their employers subscribed. Allstate terminated the policy upon written notice, as provided by the terms of the policy. Although the policy expressly provides that benefits are paid only for medical expenses incurred by an individual while the policy is in force, Petitioners claim that they have a "vested" right to receive benefits for medical expenses incurred by them after the termination of the policy for sickness or illness sustained by them prior to termination.

Allstate rejected these claims based on the express terms of the policy and applicable law.

B. Statement Of Facts

1. Petitioners' Coverage Under The Group Policy

In or about April 1981, Aul Pipe & Tubing, Inc. ("Aul Pipe") made application to participate in the First Insurance Trust to provide group medical expense benefits to its employees and their eligible dependents under

Allstate's Group Policy No. 64003477 (the "Group Policy") issued to the First Insurance Trust. Aul Pipe's application was approved and coverage under the Group Policy became effective for certain Aul Pipe employees and their dependents effective May 1, 1981. [CR 69, pp. 40-41, ¶¶ 3, 5, 6; CR 49, pp. 5-6, ¶ 13.]

Petitioner Henry Aul, Aul Pipe's president, enrolled for employee coverage and dependent coverage, including coverage for his spouse, Petitioner Grayce Aul. [CR 69, p. 41, ¶ 6; CR 49, p. 3, ¶¶ 5-6.] Thereafter, Grayce Aul began receiving treatment for a liver condition and made claims under the Group Policy for expenses in connection with such treatment, and those claims were paid. [CR 49, pp. 8-9, ¶ 18.]

On or about February 17, 1989, Allstate mailed a notice to Aul Pipe advising it that coverage under the Group Policy would terminate on May 1, 1989 at 12:01 a.m. [CR 49, pp. 9-10, ¶ 21.] Effective May 1, 1989, Allstate terminated the Group Policy and terminated coverage thereunder for all employees of all employers participating in the First Insurance Trust. [CR 69, p. 41, ¶ 7; CR 49, pp. 9-10, ¶ 21.]

2. The Group Policy Expressly Provides That Allstate May Terminate The Group Policy Upon Written Notice.

The Group Policy expressly provides that it may be terminated by Allstate on written notice under the section "Termination of the Group Policy or the Employer's Plan":

> "We may end the group policy on any premium due date after the first policy anniversary. To do this, we must give at least 60 days written notice to the Policyholder." [CR 69, p. 76.]

In addition, Allstate must give written notice to the employer:

> "If we end the Employer's Plan, we must give written notice at least 31 days in advance." [*Id.*]

3. The Group Policy Expressly Limits Benefits Payable To Those Expenses Incurred By An Insured While Coverage Is In Force.

Petitioners' claim to "vested" benefits for medical expenses incurred after termination of the Group Policy presumably derives from, among other things, the Group Policy's "maximum benefit." [Petition, pp. 7, 11-17.]

The Group Policy's Schedule of Benefits provides as follows:

> "MEDICAL MAXIMUM: $1,000,000 DURING AN INSURED'S LIFE-TIME." [CR 69, p. 78.]

The Schedule is further explained under the heading "Comprehensive Medical Insurance" as follows:

> "MAXIMUM BENEFIT
>
> * * *
>
> **"Medical Maximum**
>
> "The Medical Benefits for each insured person may not exceed the

> Medical Maximum shown in the Schedule of Benefits." [CR 69, p. 56.]

Thus, the Group Policy provides that a maximum amount of $1,000,000 in benefits may be paid to an individual. Benefits are only paid, however, for expenses incurred while the Group Policy is in force and effect.

The Group Policy expressly limits the medical expense benefits available to "Eligible Expenses" incurred *while an individual is insured*:

> "**MEDICAL BENEFIT**
>
> "The Medical Benefit is paid for eligible Expense incurred for an injury or sickness *while insured* . . . In no event may the Medical Benefit exceed the proper maximum shown in the Schedule of Benefits." [CR 69, p. 55 (emphasis added).]

"Eligible Expense" is defined as meaning "the following types of Expense *incurred* for an Injury or Sickness while insured . . ." [CR 69, p. 56 (emphasis added).]

Further, the Group Policy defines "Expense" to mean:

> "a charge a person is legally obligated to pay. 'Expense' is deemed to be *incurred on the date the service or supply is furnished.*" [CR 69, pp. 65 (emphasis added).]

Finally, the Group Policy defines when coverage terminates as follows:

"**TERMINATION OF INSURANCE**

EMPLOYEES' INSURANCE

Subject to the Continuance of Insurance provision, your insurance ends when the first of these events takes place:

- the date the group policy or the Employer's Plan ends . .
  The end of insurance will not affect any claim for a loss that took place while the insurance was in force . . . ."

A similar provision applies to dependents' insurance. [CR 69, pp. 47-48.]

Thus, the Group Policy provides benefits only for expenses incurred while coverage is in force; it does not provide benefits for expenses incurred after termination of coverage unless, as indicated below, the individual is entitled to extended or continued benefits.

4. The Group Policy Provides Extended Benefits Or Continued Benefits To Individuals In Certain Circumstances When Their Coverage Terminates.

The Group Policy provides additional, limited benefits to persons in certain circumstances when their coverage would otherwise terminate.

In the case of the termination of the Group Policy, a three month extension of benefits is provided when a person is hospital confined:

"**EXTENSION OF BENEFIT**

We will pay the medical benefit after a person's insurance ends if:

- insurance ends because the Employer's Plan ends;
- the person is confined in a Hospital on the day the insurance ends;
- the person stays confined until the expense is incurred;
- the Expense is directly related to the confinement;
- the Expense is incurred within three months after the day insurance ends; and
- the person has not become covered by another group plan offering essentially the same coverage for the confinement." [CR 69, pp. 74-75.]

Further, the Group Policy also provides that insurance may be continued after termination if an employee is totally disabled, on leave of absence or on temporary layoff, for a period of no longer than three months:

"**CONTINUANCE OF INSURANCE**

If you go on an approved leave of absence or temporary layoff, or are Totally Disabled, your Medical Expense Insurance may continue until the first of these events take place:

- the date the group policy or the Employer's plan ends;

- the date the group policy or the Employer's Plan is changed to end insurance for the class to which you belong;
- the date the Employer stops paying the premium for your insurance;
- the date the leave or layoff or Total Disability ends; or
- the date the leave or layoff or Total Disability has lasted three months." [CR 69, p. 58.]

Finally, regardless of whether coverage is extended or continued, the Group Policy provides a medical conversion privilege under which an insured whose coverage terminates because the Group Policy ends may elect to purchase an individual policy from Allstate without proof of insurability. [CR 69, pp. 62-63.]

C. The District Court's Decision

Based on the express terms of the policy, the District Court held that the Group Policy expressly limits benefits to expenses incurred while the policy is in effect and that Petitioners do not have a right to "vested" benefits. It therefore granted Allstate and Old Kent Bank's motion for summary judgment. [CR 80.]

In ruling in favor of Respondents, the District Court rejected "any reading of [ERISA] requiring that welfare plans vest. To [do] so would subvert the desire of Congress not to incorporate the vesting requirements for welfare plans." [CR 80, p. 6, ¶ 13.] The District Court also rejected Petitioners' contention that a vesting requirement should be adopted as federal common law. [CR 80, pp. 10-14.]

Finally, turning to the proper construction of the Group Policy, the District Court held that "there is nothing in these provisions to give rise to any ambiguity or suggestion that rights to coverage vest under the comprehensive medical coverage of the policy. The conclusion is buttressed by review of the whole policy." [CR 80, p. 20, ¶ 41.]

D. The Ninth Circuit's Decision

The Ninth Circuit, in an unpublished Memorandum Decision filed January 22, 1992, affirmed the District Court's decision.

In doing so, the Court, applying the normal rules of contract construction, interpreted the Group Policy as a whole and found that it "unambiguously precludes the vesting of benefits . . ." [Petition, Appendix B, p. 10.]

By order filed July 15, 1992, the Ninth Circuit denied Petitioner's petition for rehearing and rejected the suggestion for rehearing en banc. [Petition, Appendix A.]

REASONS WHY THE PETITION SHOULD BE DENIED

The Petition for Writ of Certiorari should be denied.

In the first question, Petitioners urge this Court to ignore the plain wording of the contract and do that which Congress has refused to do, *i.e.*, adopt a rule requiring "vesting" for employee welfare benefit plans. This case does not properly raise that question, however. Rather, as both the District Court and the Ninth Circuit recognized, the plan language at issue is very detailed, specific and unique and unambiguously precludes vesting. This Court should not review a question which

turns on the alleged ambiguity of a plan which in fact is not ambiguous.

Similarly, the second question also is not properly raised by this case. The rule of *contra proferentem* that Petitioners urge the Court to establish, construes insurance policies such that ambiguities are construed against the insurance company. Again, since the policy at issue simply is not ambiguous, the Court need not reach this issue.

Finally, the state court rule which Petitioners claim is "saved" from ERISA preemption as California state decisional law regulating insurance, not only does not regulate the "business of insurance" within the test adopted by this Court, but does not even represent California law on the proposition for which Petitioners advance the decision. Thus, the Court should not review the third question.

Accordingly, this case turns on the specific wording of a number of very detailed, specific and unique provisions in the insurance policy at issue. The inquiry is highly fact specific. Although the questions presented by the Petition are important to the parties, there is no public importance associated with their outcome and the questions are not of sufficient importance to warrant review by this Court.

I.

THE FIRST QUESTION DOES NOT PRESENT A QUESTION OF GENERAL IMPORTANCE

The first question presented by the Petition is whether where the Group Policy expressly limits medical expense benefits to those expenses incurred while the policy is in force, and where Congress has expressly required "vested" benefits only for pension plans, this Court should rewrite the Group Policy, override Congress' legislation in this area, and establish federal law requiring the "vesting" of benefits under welfare benefit plans. In essence, Petitioners would have the Court find ambiguity where none exists and rewrite ERISA in a manner in which Congress has refused.

A. Petitioners Are Not Entitled To "Vested" Benefits Under The Terms Of The Group Policy.

Petitioners base their claim to "vested" benefits on a reading of isolated phrases in the Group Policy. An analysis of the *entire* policy, however, reveals that Petitioners' claims are misplaced and that the Group Policy does not provide the "vested" benefits they seek.

Under the express terms of the Group Policy, an individual is entitled to medical benefits only for expenses incurred while the policy is in force. In particular, the Group Policy provides:

> "The Medical Benefit is paid for Eligible Expense incurred for an Injury or Sickness *while insured.*" (Emphasis added.)

The clear intent of this language was to provide coverage only with respect to expenses incurred while the policy was in force. That intent was further clarified by the provision of the Group Policy stating that an individual's insurance ends on the date of termination of the policy:

> "Your insurance terminates . . . the date the Group Policy ends."

The phrasing of the Group Policy not only provides for benefits for covered medical expense charges incurred by an insured individual "while insured," but it also extends coverage beyond termination only for a limited time period, and only in limited circumstances, under the Extension of Benefits and Continuance of Insurance provisions.

When the Group Policy is read as a whole, it provides only for limited post-termination benefits, not the unlimited, lifetime coverage Petitioners seek. If Petitioners' claim that they are entitled, after termination of Group Policy coverage, to benefits for expenses incurred after termination, is correct, it would render the Extension of Benefits and Continuance of Insurance provisions meaningless.

Thus, the Group Policy provides for specific, limited post-termination benefits; it does *not* provide for the type of unlimited, lifetime coverage sought by Petitioners.

In the face of this clear language, Petitioners contend that three phrases in the Group Policy, when viewed in isolation, provide them with a right to "vested" benefits.

First, Petitioners claim that they have a right to unlimited, "lifetime" benefits for expenses incurred by them even after policy termination due to policy language providing a maximum benefit. [Petition, pp. 7,

11-17.] The policy must be read as a whole, however. As the other policy provisions, discussed above, make clear, the "maximum benefit" refers to the *amount* of benefit, not the *time period* during which benefits will be paid. If this were not the case, the language in the Group Policy limiting benefits to expenses incurred while the policy is in force, and providing extended and continued benefits after the policy terminates, would be superfluous.

The second phrase upon which Petitioners rely provides that "The medical benefit is paid for Eligible Expense incurred for an Injury or Sickness while insured." According to Petitioners, the provision must be read such that the policy pays benefits for expenses incurred after the termination of the policy for an injury or illness that occurred while the Policy was in force. [Petition, pp. 8-9, 21-24.]

This argument not only ignores the rest of the policy but completely misconstrues the plain meaning of this language. Nowhere is there any language, as Petitioners in effect would insert, which states that benefits are payable for an injury or sickness that arose while the insured was covered by the policy regardless of when the expenses are incurred. Instead, the plain language of the provision expressly limits benefits to (1) expenses incurred, (2) for an injury or sickness, (3) while insured. In other words, expenses must be incurred for an injury or sickness, *as defined by the policy*, while insured. As the District Court noted, "[t]he definitions of 'injury' and 'sickness' do not speak of the time they were incurred; only medical expenses are incurred at a given time." [CR 80, p. 19, ¶ 38.] Indeed, even under Petitioners' reading of the provision, expenses would be paid only for injury or sickness *while insured*. Here, the post-termination benefits sought are to cover medical

expenses for injury or sickness to Petitioners while they are *not* insured.

The third phrase upon which Petitioners rely is "The end of insurance will not affect any claim made for a loss that took place while the insurance was in force." According to Petitioners, this provision means that termination of the policy will not affect claims for eligible expenses incurred after the termination of the policy for injury or sickness that occurred while the policy was in force. [Petition, pp. 8-9, 21-24.]

To reach this result, however, Petitioners totally ignore those portions of the Group Policy limiting benefits to expenses incurred while the policy is in effect and limiting benefits available post-termination to continued and extended benefits. Indeed, it is submitted that even when viewed in isolation the provision at issue does not give rise to "vested" benefits. Instead, by its plain terms, the provision merely states that the termination of coverage will not affect *claims* for expenses incurred prior to policy termination. This reading is reinforced by the fact that the provision is found in the general, "Insuring Provisions" section of the policy, which applies to life and accidental death insurance benefits as well as to medical expense insurance benefits. In this regard the provision operates, for example, to provide that accidental death benefits will be paid if the specific loss in question, *i.e.*, death or loss of limb or an eye, occurs within 90 days of an accident. [CR 69, p. 53.]

The District Court correctly rejected Petitioners' claim on this score, noting that:

> ". . . read in context with the express limitations in the contract, that reading is improbable. The clause means that, notwithstanding the termination of insurance, you can still file claims

> for insurable expenses that occurred before termination, even if you file the claim after termination. Thus: the end of insurance will not affect any *claim* made for a loss that took place while the insurance was in force. This interpretation of the language is one that naturally flows from the words. Furthermore, it avoids plaintiff's reading, which would subvert the remainder of the limitations expressly stated in the policy." [CR 80, p. 18, ¶ 35 (emphasis in the original).]

The Ninth Circuit agreed, finding that the Group Policy "unambiguously precludes the vesting of benefits." [Petition, Appendix B.]

B. ERISA Does Not Require The "Vesting" Of Welfare Benefits.

ERISA specifically draws a distinction between "employee *pension* benefit plans" (which provide pension benefits which, by definition, vest for future availability) and "employee *welfare* benefit plans" (which provide, among other things, medical expense benefits during the period coverage exists). *Compare* 29 U.S.C. § 1002(1) *with* § 1002(2)(a). Congress included both pension and welfare plans in ERISA's reporting and disclosure requirements, 29 U.S.C. §§ 1021-1031, and standards of fiduciary conduct governing plan administration, 29 U.S.C. §§ 1101-4. ERISA, moreover, assures the protection of vested *pension* benefits by prescribing participation requirements, funding requirements, and vesting and accrual schedules, 29 U.S.C. §§ 1051-61, 1081-86, and by providing that an

employee's right to his or her normal retirement benefit shall be "nonforfeitable," 29 U.S.C. § 1053(a). Congress, however, expressly *excluded* welfare plans from ERISA's participation and vesting and funding requirements. 29 U.S.C. §§ 1051(1), 1081(a).

As this Court stated in *Massachusetts v. Morash*, 490 U.S. 107, 119 (1989):

> ". . . ERISA's vesting and funding requirements do not apply to welfare benefit plans . . . "

Similarly, in *West v. Greyhound Corp.*, 813 F.2d 951, 954 (9th Cir. 1987), the Court held that:

> "ERISA . . . expressly exempts employee welfare benefit plans from the sections concerned with vesting and accrual. 29 U.S.C. § 1051(1). While ERISA, in 29 U.S.C. § 1322, also guarantees the payment of all nonforfeitable benefits, this protection is applicable only to pension, stock bonus or profit-sharing plans. 29 U.S.C. § 1321(a); 26 U.S.C. § 401(a). *There is no language in ERISA which provides for the accrual of welfare benefits or guarantees that such benefits are vested or nonforfeitable.*" (Emphasis added.)

Numerous other courts have agreed that ERISA does not require the "vesting" of benefits under welfare benefit plans. *See, e.g., Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 491 (2nd Cir. 1988); *Turner v. Local No. 302, International Brotherhood of Teamsters, etc.*, 604 F.2d 1219, 1225 n.5 (9th Cir. 1979); *Coleman v. General Elec. Co.*, 643 F.Supp. 1229 (E.D. Tenn. 1986), *aff'd*,

822 F.2d 59 (6th Cir. 1987); *Hebert v. Red Simpson, Inc.*, 544 So.2d 751, 753 (La.App. 1989).

Accordingly, since ERISA does not require the "vesting" of medical expense benefits, "vesting" should not be read into a plan, as Petitioners attempt to do here, unless the plan explicitly and unambiguously so provides. The Aul Pipe Plan simply does not provide for the vested benefits Petitioners seek.

II.

THE SECOND QUESTION DOES NOT PRESENT A QUESTION OF GENERAL IMPORTANCE

The second question presented by the Petition is whether as a matter of federal common law ambiguities in an ERISA plan are to be construed under the rule of *contra proferentem*.

This question is not of sufficient importance to warrant review by this Court under Supreme Court Rule 10.1(c). Rather, this case does not properly present this question because, as noted above, there is no ambiguity in the plan at issue.

As shown below, Petitioners confuse the difference between rules of interpretation, which seek the parties' intent, and contract rules of construction, which are applied only if the intent cannot be determined. Under the law of trusts, which is incorporated in ERISA, the plan documents must be read by the plan administrator not under the contract doctrine of *contra proferentem*, but in light of all the circumstances, including the settlor's intent. *Firestone Tire & Rubber Co. v. Bruch*, 489

U.S. 101, 109 (1989); *Restatement (Second) of Trusts*, § 164.

It is submitted that terms in ERISA insurance policies, just like terms in non-ERISA insurance policies, are to be interpreted in light of the settlor's intent and "in an ordinary and popular sense as would a [person] of average intelligence . . . . We will 'not artificially create ambiguity where none exists.'. . . 'If a reasonable interpretation favors the insurer and any other interpretation would be strained, no compulsion exists to torture or twist the language of the policy.' " *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1441 (9th Cir. 1990) (citations omitted), quoting *Allstate Insurance Co. v. Ellison*, 757 F.2d 1042, 1044 (9th Cir. 1985).

Contra proferentem is not aplied under contract law except as a constructional tool of last resort when the parties' intent cannot be determined. *Taylor v. Continental Group*, 933 F.2d 1227, 1233-34 (3rd Cir. 1991); *Record Club of America, Inc. v. United Artists Records, Inc.*, 890 F.2d 1264, 1271 (2nd Cir. 1989); *see also, Lippo v. Mobil Oil Corp.*, 776 F.2d 706, 714 n. 15 (7th Cir. 1985); *Quad Constr., Inc. v. Wm. A. Smith Contracting Co.*, 534 F.2d 1391, 1394 (10th Cir. 1976). Judge (now Justice) Anthony M. Kennedy summed up this point as follows:

> "A rule for construing contracts against the author is not an alternative to construing it as the parties intended. It is to be applied after the court has inquired into the intent of the parties, and then only if its meaning remains uncertain."

Board of Trade of San Francisco v. Swiss Credit Bank, 597 F.2d 146, 149 (9th Cir. 1979).

Indeed, under any rule of interpretation, be it federal law, California law, or the law of some other jurisdiction,[1] the Court must apply certain rules of interpretation to ascertain the intent of the parties to a contract *prior* to using a rule of construction, such as the one resolving ambiguity against the drafting party. *See, e.g.*, California Civil Code §§ 1636, 1654. These rules require the Court to construe the contract as a whole, not in isolated parts, so as to give effect to every provision. *See, e.g.*, California Civil Code § 1641. Whenever reasonably possible, meaning must be given to every sentence, clause and word, so as to avoid rendering parts of a policy inoperative. *Holz Rubber Co. v. American Star Ins. Co.*, 14 Cal.3d 45, 533 P.2d 1055, 120 Cal.Rptr. 415 (1975). A construction which would give effect to one sentence of a policy, but completely ignore an entire paragraph dealing with the same subject matter, is *not* required by the rule, espoused by Petitioners, that an insurance policy should be liberally construed in favor of the insured. *Henricks v. Metropolitan Life Ins. Co.*, 7 Cal.2d 619, 631, 61 P.2d 1162 (1936).

The proper application of these rules of contract interpretation, as a matter of the "uniform federal law" which Petitioners seek to invoke, *see* Petition, pp. 18-24, leads to the conclusion that Petitioners have no right to benefits under the Group Policy for expenses incurred by them after termination of coverage.[2]

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[1] It is Respondents' position that if and to the extent state law regulates the plan at issue, the law of Illinois, not California, applies. However, for the sake of convenience and to avoid burdening the Court with a discourse on this issue, Respondents refer to California law in this section and in section III, *infra*, because that is the law relied on by Petitioners.

[2] It is especially important that these rules be applied in determining whether medical expense benefits "vest" under employee welfare

(continued)

Indeed, the terms of the Group Policy are not even ambiguous under the very case relied on by Petitioners for this proposition, *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir.), *cert. denied*, ___ U.S. ___, 111 S.Ct. 581, 112 L.Ed.2d 587 (1990). Even the *Kunin* court recognized that the rule of *contra proferentem* is applied only "if after applying the normal principles of contractual construction, 'the insurance contract is fairly susceptible of two different interpretations . . .' " *Id.* at 539 (citation omitted). Moreover, the *Kunin* court itself proceeded to analyze the entire policy at issue in that case, not just an isolated phrase or phrases, *id.* at 541, as Petitioners would have this Court do here.

In their attempt to somehow, someway, obtain a benefit for which they did not bargain and which Congress refused to grant, Petitioners ignore this Court's ruling in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), that in construing the terms of the policy, the Court must seek out the intent of the trustor. The Court should not, as Petitioners urge it to do, construe the policy in an effort to find ambiguities where none exist and to construe them against the drafter. The Court may not prefer one party's interpretation over that of another.

Accordingly, the Court need not reach the second question, which is not properly presented by this case.

(fn. continued)
benefit plans. It would be anomalous to utilize state common law rules of construction to bring in, via the "backdoor," a mandated vesting requirement which Congress itself rejected. The Court should not utilize preempted state law rules to rewrite ERISA.

III.

THE THIRD QUESTION DOES NOT PRESENT A QUESTION OF GENERAL IMPORTANCE

The third question presented by the Petition is whether the California Court of Appeal's interpretation of a particular insurance policy in the case of *Fields v. Blue Shield of California*, 163 Cal.App.3d 570, 209 Cal. Rptr. 781 (1985), is "saved" from preemption by ERISA's "saving" clause, 29 U.S.C. § 1144(b)(2)(A), as a "law of any State which regulates insurance." Like the first two questions presented by the Petition, this question too does not present an issue of general importance to warrant review by the Court under Supreme Court Rule 10.1(c).

A. The Fields Decision Is Not "Saved" From Preemption.

ERISA provides that it preempts state law relating to employee benefit plans. 29 U.S.C. § 1144(a). State law which "regulates insurance," however, is "saved" from preemption by virtue of the "saving" clause. 29 U.S.C. § 1144(b)(2)(A). In determining whether state law is "saved" from preemption, this Court has adopted the three part test developed under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011, *et seq.* for interpreting the phrase "business of insurance." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48-49 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743-47 (1985). Under the three part test, a practice falls within the "business of insurance" for purposes of the McCarran-Ferguson Act, and, consequently, for the purpose of

determining whether it is saved from preemption under ERISA's "saving" clause, if (1) the practice has the effect of transferring or spreading a policyholder's risk; (2) the practice is an integral part of the policy relationship between the insurer and the insured; and, (3) the practice is limited to entities within the insurance industry. *Pilot Life Ins. Co. v. Dedeaux, supra*, 481 U.S. at 48-49. Here, the three-part test is not met.

The "practice" at issue, the *Fields* decision, is but a rule of interpretation enunciated by a single court. Indeed, as the District Court noted in granting Allstate and Old Kent Bank's motion for summary judgment, *Fields* is not even followed or "universally accepted" in California. [CR 80, pp. 12-13, ¶ 25.] The *Fields* decision is not a law that "require[s] an insurer to provide a certain kind of benefit to cover a specified illness or procedure whenever someone purchases a certain kind of insurance" and, therefore, subject to the "saving" clause. *Metropolitan Life Ins. Co. v. Massachusetts, supra*, 471 U.S. at 728. Rather, it is a common-law rule of interpretation of a particular contract in the particular circumstances of that particular case.

The "*Fields* rule" does not effect the spread of risk of loss. As the Ninth Circuit, applying this Court's decision in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), noted in *Hahn v. Oregon Physicians Service*, 689 F.2d 840, 843 (9th Cir. 1982), the "business of insurance" only involves an insurer's underwriting and risk spreading functions. Similarly, in *Addrisi v. Equitable Life Assur. Soc.*, 503 F.2d 725, 728 (9th Cir. 1974), the Court noted that the McCarran-Ferguson test focuses on the relationship between an insurance company and its policyholders. And, in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982), this Court emphasized that "[t]he transfer of risk from

insured to insurer is effected by means of the contract between the parties — the insurance policy — and that transfer is complete at the time the contract is entered. . . . the insurance policy defines the scope of risk assumed by the insurer from the insured."

Judicial decisions, such as *Fields*, which merely apply state law principles of contract construction, do not effect the transfer of risk by means of the insurance policy. *Brewer v. Lincoln National Life Ins. Co.*, 921 F.2d 150, 153 (8th Cir. 1990), *cert. denied*, ___ U.S. ___, 111 S.Ct. 2872, 115 L.Ed.2d 1038 (1991); *McMahan v. New England Mutual Life Ins. Co.*, 888 F.2d 426, 429 (6th Cir. 1989). Rather, they rely on *ad hoc*, post-contract analyses to construct a right to benefits not contemplated by the insurer and not underwritten into the premium. It is precisely this type of *ad hoc*, case by case, post-contract type of interpretation that Congress, by enacting ERISA, intended to avoid by enacting a broad preemption clause of "unparalleled breadth" in order to secure uniformity in employee benefit plans and to avoid the uncertainty of a host of conflicting and contradictory judicial interpretations. *See Holland v. Burlington Industries, Inc.*, 772 F.2d 1140, 1147 (4th Cir. 1985), *cert. denied*, 477 U.S. 903, *and aff'd*, 477 U.S. 901 (1986); *Keel v. Group Hospitalization Medical Services, Inc.*, 695 F.Supp. 223, 227 (E.D. Va. 1988).

As the Ninth Circuit noted in *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1440 (9th Cir. 1990):

> "In *Kanne* [*v. Connecticut General Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988), *cert. denied*, ___ U.S. ___, (1989)], we held that state laws of insurance policy interpretation do not qualify for the saving clause exception

> and are preempted. If we were to preserve 50 different state laws of insurance policy interpretation as federal common law, we would in effect add an item to the saving clause which we have already said that Congress did not mean to include."

B. Even Assuming, For The Sake Of Argument, That The Fields Decision Is "Saved" From Preemption, It Does Not Reflect California Law On the "Vesting" Issue And Its Holding Is Inapposite.

Even if the *Fields* decision is saved from preemption, the very California law which Petitioners seek to incorporate does *not* require an individual's benefits to "vest" upon the termination of group coverage. Rather, California Insurance Code section 10128.2 expressly negates the existence of plaintiffs' alleged "vested rights."

Section 10128.2, entitled "Extension of benefits; discontinuance of policy," provides a 12 month extension of benefits period for employees or dependents who become totally disabled while insured under the policy and who continue to be totally disabled upon the termination of the policy.

In addition, California Insurance Code section 12692 provides a 90 day extension of benefits period in certain circumstances where the section 10128.2 continuance is not applicable.

Thus, California law expressly defines the post-termination benefits that an insurance company must make available to individuals when their group coverage terminates.

The decision in *Fields v. Blue Shield of California*, 163 Cal.App.3d 570, 209 Cal.Rptr. 781 (1985), upon which Petitioners rely in this regard, does not alter this conclusion. The holding in *Fields* was premised on an "ambiguous" modification of the policy at issue in that case, and is not applicable here. Moreover, *Fields* did not deal with the issue of post-termination benefits, nor did it involve any statutory provisions governing the benefits sought, as does this case.

CONCLUSION

The Petition for Writ of Certiorari in this case presents questions which are of limited significance because they were resolved against Petitioners by both courts below based upon the particular and highly unique facts of the case. When these facts are analyzed, it is clear that the terms of the policy itself, statutory law and decisional law simply do not provide Petitioners with the right to the vested benefits which they seek.

The Petition is nothing more than a last-gasp effort by Petitioners to have this Court step in, rewrite the policy, and do what both Congress and the California legislature have refused to do in terms of requiring that employee welfare benefits be "vested." The Petition, therefore, should be denied.

DATED: November 12, 1992.

Respectfully submitted,

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APPENDIX A

STATUTES, REGULATIONS AND RULES

29 U.S.C. § 1002. Definitions

For purposes of this subchapter:

(1) the terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

(2)(A) Except as provided in subparagraph (B), the terms "employee pension benefit plan" and "pension plan" mean any plan, fund or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that by its express terms or as a result of surrounding circumstances such plan, fund, or program--

(i) provides retirement income to employees, or

(ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond,

regardless of the method of calculating the contributions made to the plan, the method of calculating benefits under the plan or the method of distributing benefits from the plan. . . .

29 U.S.C. § 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not extempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities . . . .

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State . . . .

California Insurance Code § 10128.2. Extension of benefits; discontinuance of policy

Every policy containing a life insurance benefit shall contain a reasonable extension of such benefit upon discontinuance of the policy with respect to employees who become totally disabled while insured under the policy on or after the date this article becomes applicable to such policy and who continue to be totally disabled at the date of discontinuance of the policy. Every policy containing a loss of time benefit, or a hospital, medical, or surgical expense benefit shall contain a reasonable extension of such benefits upon discontinuance of the policy with respect to employees or dependents who become totally disabled while insured under the policy on or after the date this article becomes applicable to such policy and who continue to be totally disabled at the date of discontinuance of the policy. . . .

(d) Every policy providing hospital, medical or surgical benefits on an expense-incurred or service basis shall be deemed to include a reasonable extension of such benefits upon discontinuance of the policy if it provides benefits for covered expenses directly relating to the condition causing total disability existing at the time premium payments for the employee or dependent cease and incurred during a period of not less than 12 months thereafter, which period shall not be interrupted by discontinuance of the policy.

That extension of benefits may be terminated at such time as the employee or dependent is no longer totally disabled or at such time as a succeeding carrier may elect to provide replacement coverage to that employee or dependent without limitation as to the disabling condition.

(e) The benefits payable during any extension of benefits may be subject to all limitations or restrictions contained in the policy.

California Insurance Code § 12692. Continuation benefit coverage; duration; eligible dependents; conditions of availability of coverage

On and after January 1, 1985, every insurer and nonprofit hospital service plan issuing group disability insurance which covers hospital, medical, or surgical expenses shall offer to group policyholders a continuation benefit which if selected, shall have a duration of at least 90 days and which shall be offered consecutively to any federal requirement for continuation benefits. The terms and conditions shall include continuation benefit coverage for widows, widowers, divorced or legally separated spouses, spouses of covered employees becoming entitled to benefits under Title XVIII of the Social Security Act, and their dependents, including dependent children who cease to be dependent children under the plan, who were covered by the group contract on the date of termination of coverage. However, any existing provisions of law regarding termination of a dependent child status shall not be affected by this section.

The continuation of coverage shall be available only under the following conditions:

(a) Those eligible remain within the State of California, although the departure of a dependent child to another state shall not invalidate the continuation provisions for any other family members.

(b) Those eligible do not marry or remarry, although the marriage of any dependent child shall not invalidate the continuation provisions for other family members.

(c) Those eligible are not eligible for any comparable state, federal, or private group medical plan, although the eligibility of any dependent child shall not

invalidate the continuation provisions for other family members.

(d) Those eligible do not find employment with an employer that has a group plan of its own, even if the plan is less substantive, although the entry into such an employee plan by a dependent child shall not invalidate the continuation provisions for other family members.

(e) The group policy is not terminated or the employer's participation in the group policy is not terminated.

(f) Those eligible do not knowingly furnish incorrect information or otherwise improperly obtain the benefits of the plan.

(g) The continuing individual shall pay the premium amount in the manner specified in the group policy for both his or her share of the premium and the group policyholder's share, if any.

(h) Eligible persons under this section shall be notified in the same manner required for conversion notification pursuant to Section 12689. Every insurer shall communicate the availability of such coverage to all group policyholders and to all prospective group policyholders with whom they are negotiating.

Supreme Court Rule 10. Considerations Governing Review On Writ Of Certiorari

.1. A review on writ of certiorari is not a matter of right, but of judicial discretion. A petition for a writ of certiorari will be granted only when there are special and important reasons therefor. The following, while neither controlling nor fully measuring the Court's discretion, indicate the character of reasons that will be considered:

. . .

(c) When a state court or a United States court of appeals has decided an important question of federal law which has not been, but should be, settled by this Court, or has decided a federal question in a way that conflicts with applicable decisions of this Court.